			1 - For State Registrar	State of Maryland	d / Depa		Health and	Mental Hygi	•	)	9501
	G 6		1. Decedent's Name (First, Middle, Last)					2. Date of Deatl	h		3. Time of Death
	Physici /Medio		Stanislaus Kost	ka David	Gardi	ner		March 9	,	Year	1517 <sup>M</sup>
>	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea		4c. County o	Death	
			Coastal Hospice at	the Lake		Salisk			Wicom	ico	_
	Funeral Director		215-36-8336	7. Age (In yrs. I 66	ast birthday) Yrs.	If Under 1 Year Months Days			40°	Coun	lace (State or Foreign try) yland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	f sho	ō	Maryland Wicomico		alisbu	irv					1 ☐ Yes 2 🔏 No
	28a	Director	10e. Street and Number		411000	10f. Zip Code		10	Og. Citizen of W	nat Cour	try?
	death with the Maryland ms 23a or 28a-f show	Ö	1529 Woodridge Dr	rive		218	304		USA		
	death	Funerai	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of	Hispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race		
٥	or Ite	品	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 21 No If Yes, Give		1 ☐ Yes 2K☐ No		no rican, etc.)	Specify:	, White,	
3	urel',	d by	3 Widowed 4 Divorced	Year or Dates:					Зреспу.	WN.	ite
215-0036	"nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Bus	iness/Inc	dustry
7	withii ene. than	m m	Elementary/Secondary (0-12)	College (1-4or 5+)	Finar	ncial Age	nts Oper	ations	State o	f Ma	rvland
0	Hygi other	ပိ	17. Father's Name (First, Middle, Last)			Chief	18. Mother's Na	ıme (First, Middle, M			-7
yland	Aental Aental rked tic ev	To Be	Stanislaus Kostka	Gardiner			Crezen	tia Mulla	ney		
Mary	and hard		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Stree	t and Number or F	Rural Route Number,	City or Town, 5	tate, Zip	Code)
≥,`	and ealth m 27		Sandra L. Gardine				ge Dr.,	Salisbury			
0	Fof H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State 7/17	lace of Dispo emetery, crer	sition (Name of matory or other pla Memoria	ice)		20c. Location - C	•	
	tment: tant:		*4 □ Donation 5 □ Other (Specify)	P	ark		0/1		Salisbu		
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event. If a Modical Executor could be notified at once.		21. Signature of Funeral Service License	1 CESP	11. 5	olloway Ol Snow	funeral Hill Rd.	Home Prof, Salisbu	essiona ry, MD	l As 2180	sociation 4
Records, P.O. Box 68/60,	ticien: The law requires that the death certificate be executed  rectificate has been signed by the attending physicien and interpretation and int	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of the consequence of t	uence of):  uence of):  uence of):  ncy death 3 [ eath 5 [	]Ectopic pregnand ] Other (specify) _			n 24b. W	of delive	any Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
VII	sicien: certifica rector, p	9	25. Was case referred to medical				26. Place of De	eath (Check only one			26 140
	S S S	To B	examiner? -1 Yes 2 Xo	ospital: Inpatient 2	ER/Outpatier	nt 3 DOA		Home 5 ☐ Reside	-	(Specif	γ)
ion or	ing Viter une	ertification;	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju Wo	iry at ork? ] Yes 2 □ No	28d. Describe ho			
DIVISION	ne Hospitel or Attendi 124 hours after death 16 Funerel Director: A bletely filled in by the fi	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Numbe , State)	r or Rura	l Route Number,
	To the Hospi within 24 hou To the Funer completely fill	ledicai	(Check only 2 Medicel Exemir one)	ician: To the best of my knowner: On the basis of examinal and manner stated	wledge, deatl tion and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and man ate and place, a	ner as s nd due to	tated. o the cause(s)
	To the vithin 2 To the complet	2	290. Signature and title of certifier	201/v	W	29c. Licen	262		3 - 9		
1	000		30. Name and address of person who co	Corold Hispine	PO	Print) Box 173	3 S.	elist	3-9 mo	21	802
•	Sta Registi	ate rar	31. Date filed (Month, Day, Year) MAR 1 4 20	32. Signatura Signa	ture	and)		y			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician March 11, 2006 2145 P Lois Hughes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cumberland

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Allegany Rehab Ctr. Allegany County Nursing Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 88 04/14/1917 183-46-7057 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. Inter then "nature!, or Items 23e or 28e-f show 10c. City, Town or Location 10b County 10a. State 7 is marked other then "naturel", or Items 23e or 28e-f show traumatic svent, the Madical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Ellerslie Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 111 DeVore Street (P.O. Box 15) 21509 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ Year or Dates: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 8 s 1 and 2 should be filed to the sith and Mental Hygie item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reader Grace Headley Lee James ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 15, Ellerslie, Maryland Ruth Ann James / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: It ite
any injury or otl
once. 1 Burial 2 □ Cremation 3 □ Removal from State Greene Mount Cemetery 03/16/2006 Waynesburg, PA ` 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signatury of Funeral Service Licensee 404 Decatur Street, Cumberland, Maryland elever 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HY GRIGNSIVE Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No After this certificate To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 1 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-14865 John ustrano 30. Name and address of person who completed cause of death (Item 23 (Type, Print) 500 Memorial Avenue, Cumberland, MD 21502 Robustiano J. Barrera, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar

		1	For State Registrer	State of Maryland	-	rtment of Health a	ind Ment	al Hygie	4 U U	6	09503
			1. Decedent's Name (First, Middle, Last)					ate of Death	Day	Year	3. Time of Death
	Physicia /Medic		Dorothy	Gladys	3	Hare		rch 7.	2006		3:45 P M
}	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of	f Death	1	4c. County	of Death	
			24 South Stree			Cumberland	Miller			gany	
41	Funeral		5. Social Security Number 6. Sex	M 2⊠F 85	Yrs.	Months Days Hours	Min. 8. Da	ate of Birth fonth, Day, Ye	ar)		place (State or Foreign htry)
	Director	-	220-10-4994 Usual Residence of Decedent	. 63			02/	10/192	1	Mary	land
	land ow	- h	10a. State 10b. County	10c. City, T	own or Loc	ation				1	Od. Inside City Limits
	Many Fish	ţō	MD Allega	anv	Cui	mberland					1√ Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of V	Vhat Cou	ntry?
	h wit		24 South Stre	et		21502			USA		
	deat	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify Y	es or No-		e - Americk, White,	can Indian,
9	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	,,	Specify		
8	72 hours after death with the Maryland netural; or Items 23e or 28e-f show alcal Examinations to colificat at	d by	3 ₩idowed 4 □ Divorced	Year or Dates:							White
5	"net	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occupation kind of work done during most OO NOT use retired)	of working	160	. Kind of Bu	isiness/in	dustry
12	withi ene. than	E C	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		omemaker			Home		
D	Hyg other ent,	a)	17. Father's Name (First, Middle, Last)		111		r's Name (Firs	t, Middle, Mai			
an	lid be fental fked ic ev	To B	Unknown			Має	<u> </u>		Fogtma	an	
ary	shou and N s mai		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street and Number	r or Rurai Rou	te Number, Ci	ity or Town,	State, Zip	Code)
Σ	and 2 valth in 27 in er tre		Gary E. Hare / son	n	Rout	e 2 Box 378, R	~	y, WV	26753	3	
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan neart of Heath and Mental Hygiene. Int: If time 77 is marked other than "netural, or thems 23a or 28a-f show any or other treumatic event, the Maryleal Examination into the reconstituted at		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Re	cemi	e of Dispos etery, crem	sition (Name of latory or other place)	Date	200	. Location -	City or To	own, State
Ĕ	permit. Page Department ( Important: If eny injury or once.		* 4 □ Donation □ Other (Specify)		crest	Memorial Par	k_03/10	1/2006	Cumb	erla	nd, MD
salt	Depart Import Import Inj Inj Inj Inj Inj Inj		21. Signature of Fune al Service License	e ,	/	Name and Address of Facility		,			
_	20529	1	Tolet C	Udame		4 Decatur Stre				0 21	1502
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. I e cause on each line.	Do not ente	er the mode of dying, such as o	cardiac or resp	piratory arrest,			Approximate Interval Between Onset and Death
	nysician	a a	Immediate Cause (Final disease or condition resulting in death)	meun	oni	a					lengs
	/Medical Examiner		Tesatting in dozini)	Due to (or as a consequen	ce of):						0
	¥-	6	Sequentially list conditions, if any leading to immediate	. Due to (or as a consequen	ce of):					-	
	nted Insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ć,	cate be executed physician and the burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or as a consequen	ce of):						
8760,	/sicia	· 65	C <sub>a</sub>								
9	tifical ag ph as th	Medica	VE 551111 5								
Вох	death certifica e attending ph od for use as t	lan/M	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy				e of deliv	
	0 0 0	O	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of death		Other (specify)			Mo	ทเก	Day Year
P.0	tac po	Physi	9 Unknown		- in the same	de de la companya de		230 Did tobao	00 1100 0001	ributo to t	he cause of death?
S,	Se un oc	b	Part II. Other significant conditions con	thouting to death but not resulting	ng in the ur	idenying cause given in Part I.	2				bably 4 XUnknown
Vital Record	w requires been sign should be	ompleted							-		
3ec	S 55 S	npl					2	4a. Was an autopsy performed	246. \	Were auto prior to co death?	opsy findings available empletion of cause of
al	Th ate pag	O	_					☐ Yes 2☐	No	Yes	2 🗆 No
V:E		o Be	25. Was case referred to medical examiner?	ospital:		Other	of Death (Che		- CO.		
of		-	1 ☐ Yes 2 ☒ No ''  27. Manner of Death	28a. Date of Injury 28	Outpatien b. Time of	28c. Injury at	rsing Home : 28d. [	Describe how			TY)
on	ttending P death. tor: After I the funera	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? M 1 □ Yes 2 □ N	No				
Division	of or Attending after death. I Director: After In by the fune	ifice	3 Suicide 6 Could not be determined	28e. Place of Injury - At home	, farm, stre	eet, factory, office		ocation (Stree		er or Rura	al Route Number,
ā	s afte	Certification:	4   Hollicide	building, etc. (Specify)				nty or 10 mil, 3	1210)		
	To the Hospitel or Atter within 24 hours after de To the Funerel Director completely filled in by the			sician: To the best of my knowle							
	the H in 24 the F iplete	ledicai	one)	and manner stated.							
	To	Σ	29b. Signature and title of certifier	1 - (	٢	29c. License number			Date signed		
•	5		Sang Me	alk n	ull	D0054411			March	8,	2006
	_		30. Nure and address of person who co	mpleted cause of death (Item 23	a) (Type, I	Print)					
	na	- 1	Parra -1 0 - 11	ing M D FO	Λ M		C 1	.1	M - 1	1	21502
	Th Kul	te	Beverly Calk 31. Date filed (Month, Day, Year) MAR 0 8 2006	ins, M.D., 50 Registrar's Signature		orial Avenue,	Cumber	land,	Mary1	and	21502

RALPH LEC HANKY  RALPH LEC HANKY  RALPH LEC HANKY  March 14, 2006 9  4a. Facility Name (if not institution, give street and number)  CARROLL LUTHERAN VILLAGE HEALTHCARE  Funeral Director  Funeral Director  Funeral Director  T18 - 16 - 9725  Usual Residence of Decedent  10a. State 10b. County  MD CARROLL  Usual Residence of Decedent  10b. County  MD CARROLL  WESTMINSTER  10c. City, Town or Location  T18 - 16 - 9725  Usual Residence of Decedent  10a. State 10b. County  MD CARROLL  WESTMINSTER  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  1	de City Limits Yes XXIII In,
RALPH LEC HANKY  RALPH LEC HANKY  RALPH LEC HANKY  March 14, 2006 9  4a. Facility Name (if not institution, give street and number)  CARROLL LUTHERAN VILLAGE HEALTHCARE  Funeral Director  Funeral Director  Funeral Director  T18 - 16 - 9725  Usual Residence of Decedent  10a. State 10b. County  MD CARROLL  Usual Residence of Decedent  10b. County  MD CARROLL  WESTMINSTER  10c. City, Town or Location  T18 - 16 - 9725  Usual Residence of Decedent  10a. State 10b. County  MD CARROLL  WESTMINSTER  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  10d. Institution  MD CARROLL  WESTMINSTER  10d. City, Town or Location  10d. Institution  1	ate or Foreign  A  de City Limits  Yes XXIII  In,
## As Facility Name (If not institution, give street and number)  CARROLL JUTHERAN VILLAGE HEALTHCARE  5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11. Under 1 Year	de City Limits Yes XXIII In,
The state of the s	de City Limits Yes XXIII In,
10c. Clity, Town or Location   10d. Clins	Yes 2010 in,
Elementary/Secondary (0-12)  Purpose of the state of the	21158 te
Elementary/Secondary (0-12)  Purpose of the state of the	21158 te
Elementary/Secondary (0-12)  Purpose of the state of the	21158 te
Elementary/Secondary (0-12)  Purpose of the state of the	te
8 17. Father's Name (First, Middle, Last) FRANCIS IGNATIUS HANKY FRANCES J. PRINCE  19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK HANKY — SON 25 37 UNIONTOWN ROAD WESTMINSTER, MD  20a. Method of Disposition 1	te
FRANCIS IGNATIUS HANKY  FRANCES J. PRINCE  19a. Informant's Name/Relationship (Type, Print)  FRANK HANKY - SON  2537 UNIONTOWN ROAD WESTMINSTER, MD  20a. Method of Disposition  1  Burial 2 cremation 3 Removal from State  4  Donation 5 Other (Specify)  Physician  Physician  Medical  Physician  Medical  17. Father's Name (First, Middle, Last)  FRANCIS IGNATIUS HANKY  FRANCES J. PRINCE  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Physician  1  Burial 2 cremation 3 Removal from State  FOREST LAWN CEMETERY 03/18/2006 RICHMOND,  21. Sig ture of Funeral Service Licensee  MO 1 1 9 1  22. Name and Address of Facility  MYERS-DURBORAW FUNERAL HOME, P. A.  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in dealh)  Due to (or as a consequence of):	te
FRANK HANKY - SON  2537 UNIONTOWN ROAD WESTMINSTER, MD  20a. Method of Disposition  1  Burial 2	te
Physician / Medical Physician / Medical Due to (or as a consequence of):  91 WILLIS ST. WESTMINSTER, MD 2 Approximate Approxim	te
Physician / Medical Physician / Medical Due to (or as a consequence of):  91 WILLIS ST. WESTMINSTER, MD 2 Approximate Approxim	
Physician / Medical Physician / Medical Due to (or as a consequence of):  91 WILLIS ST. WESTMINSTER, MD 2 Approximate Approxim	
Physician /Medical   23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximately   1	1157
/Medical resulting in dealth)  Due to (or as a consequence of):	imate d Between and Death
Examiner	10/3
Sequentially list conditions, if any, leading to immediate cause. Either University of Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):	
e gisis a	
687	
September 2 Septem	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did lobacco use contribute to the cause of the ca	
1   Yes 2   No 3   Probably  1   Yes 2   No 3   Probably  24a. Was an autopsy find prior to completion death?  1   Yes 2   No 3   Probably  24a. Was an autopsy performed?  1   Yes 2   No 3   Probably  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably  26. Plac of Death   Check only one)  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably  26. Plac of Death   Check only one)  27. Mannel of Death   Check only one)  28. Date of Injury   28b. Time of Injury   28b	of cause of
1 Yes 2 12 No 1 Yes 2	
The state of the s	
The state of the s	
28a. Date of Injury Work? 1 Vestural 1 Vestural 2 Could not be determined 28b. Time of Injury M 1 Vestural 2 Could not be determined 28c. Injury at Work? 1 Yes 2 No 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Date of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Date of Injury - At home, farm, street, factory, office 28c. Injury at Work? 2 No 28b. Date of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28b. Date of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28b. Date of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28c. Injury at Work. 28c. Injury at Work. 28c. Injury at Work. 28c. Injury	Number,
O TO TO THE STAND OF THE STAND	use(s)
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Ye)	_
30. Name and address of for on who completed cause of death (Item 23a) (Type, Print)    Some Area no. 295 Sporr Av. 5072 307 was him of the 21157	
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAR 1 5 2006	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death March lu, 2006 Physician Hoffmaster Arthur 7:48 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth On North Days Hours Min. Feb. 16, 1918 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Mary land 214-28-5441 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "natural", or Itame 23a or 28a-f show eny injury or other traumatic event. It a Medical Examinat must be nutified at once. 1 Tyes 2 XNo Directo Woodsboro Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21798 U.S.A. 9742 Steiner Smith Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farmer/ bus contractor dairy/ county gov't. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lewis Arthur Hoffmaster Maude Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9742 Steiner Smith Rd. Woodsboro, MD 21798 Frances Hoffmaster/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 3/13/2006 Woodsboro, MD Mt. Hope Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee Woodsboro, MD 21798 404 S. Main St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chronic obstrictive pulmonary disease **Physician** years /Medical Due to (or as a consequence of) Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). been signed by the ettending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2 No 1 Yes or Attending Physician: After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina death. м 1 ☐ Yes 2 ☐ No investigation To the Hospitel or Attendi within 24 hours after death. > To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier CU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Solarex Ct Heitzia 610 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		partment of Health and Mertificate of Death	lental Hygier	4000	09506
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles Junior	"Jake" Helmick			Pay Year	3. Time of Death
<i>)</i>	Examin		4a. Facility Name (If not institution, give stre 5 acred Hear 5. Social Security Number 6. Sex		4b. City, Town, or Location of Death  Cumberland  y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	C. County of Death	lace (State or Foreign
	Director		232-54-2549 1 MM M Usual Residence of Decedent	2□F 73 Yrs.	Months Days Hours Min.	3 Month 2 Day 1 Year	32 W V W	itry)
	Maryland a-f show	ctor	10a. State 10b. County Hampshire	e Romney	Location		1	0d. Inside City Limits 1 X Yes 2 ☐ No
	h with the 23a or 28 st be no	al Director	10e. Street and Number HC 65 Box 960		101. Zin Code 2 6 7 5 7	Un 1	Citizen of What Cour ted Stat	e's
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic avant, the Medical Examinational be notified at	by Funeral	11. Marital Status 12.  1 XX Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Whi	etc.
Maryland 21215-0036	I within 72 ho iene. r than "natur ir e Medice.	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)  (Given the second of the	edent's Usual Occupation ve kind of work done during most of workin DO NOT use retired) r .Was Employed	ng 16b. N /	Kind of Business/Ind	dustry
land ?	m - V =	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Charles Beatty	Helmick		(First, Middle, Maide Thetzel F		
Mary	and 2 shore setth and N n 27 le mai		19a. Informant's Name/Relationship ( <i>Type</i> , Nova Connell/Sis	Print) 19b. Ma H C 6	lling Address (Street and Number or Rura 5 Box 960 Romne	of Route Number, City y, WV 26	or Town, State, Zip 757	Code)
Baltimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If item 27 Is marked any injury or other traumatic as		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State 20b. Place of Dis A someten c A similar t en	position (Name of emalor) of other place) 3 - 2 1	oate 20c. -06 ⊭ęa	Location - City or To .nsSettle	wn, State ement
Ball	permit. Depert Import any inj		21. Signature of the remarks a Licensee	Ames & M	A Name and Address of Facility 1 H Oorefield, WV 26	ome 5836		
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of immediate Cause (Final	ause on each line.	4 /		20.0	Approximate Interval Between Onset and Death
, Et	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	/	s Synoi	come	1 week
/	led sit	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	prennonia			
8/60,	centificate be executed nding physicien end use as the burial-transit	al Examine	that initiated events c resulting in death) Last	Due to (or as a consequence of):	nogent repuix			
٥	rtificete ng phys	Medical	IF FEMALE:					
C. Box	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ny Day Year
JS, T	ang ang	<u>۾</u>	Part II. Other significant conditions contrib	outing to death but not resulting in the	underlying cause given in Part I.		use contribute to the	
ecord	> 40	Completed	Went HE BET	WEDAT 110 W		1 ☐ Yes 24a. Was an	24b. Were auto	ably 4 □Unknown  psy findings available
I	The ete h page					autopsy performed?	death?	npletion of cause of
Vital		o Be	25. Was case referred to real examiner? 1 ☐ Yes 2 ☑ No Hos	oital: 1 npatient 2 ☐ ER/Outpatie	26. Place of Death	ne 5 Residence	0 F10th (C (	
ō	ding Phys	n: To	27. Mann eath	28a. Date of Injury (Month, Day Year) 28b. Time		28d. Describe how in		<u>"</u>
<u>0</u>	Attending ir death. ector: After by the fune	atlo	2 Accident investigation	(month, bay , oar) linjury	M 1 Yes 2 No			
DIVISION	tal or Atten 's efter deat at Director: ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura Ite)	l Route Number,
	To the Hospital within 24 hours e To the Funaral I completely filled	edical	one)	On the basis of examination and/or i	if occurred at the time date and place a nvestigation, in my opinion, death occurre	e atch amit adt to he	nd place, and due to	the cauca(c)
)	To T To 1	Σ	29b. Signature and title of certifier CAM	DioTHERACIC SUNG	29c. License number	F2 29d. C	Date signed (Month,	Pay, Year)
	7		30. Name and address of person who common the common than the	cause of death (Item 23a) (Type	29c. License number  DOOGIFO  Print)  Seton DRIVE	# 204	eunbert.	MUD MAJOL
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 200	32. Registrar's Signature	foods			
DHI	AL 17 Day 1/00	04		P				

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 1

111 Penn Street

Baltimore, Maryland 21201

M. D.

2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09508 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 0839 :3 **Physician** 06 Ohnson opper /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and num Examiner Apl F-3 Age (In yrs. last birthday) 50 Yrs. Inder 1 Year If Under 24 Hrs.
onths Days Hours Min. KC 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** -66-8633 Months 1 ☐ M 2 🕽 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f ehow treumetic event, it is Modical Examinar must be notified al 1 AYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number or Items 23e Cc Funeral 12. Was Decedent ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 
Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 Blac by 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If lem 27 is marked other then "na eny injury or other treumetic even" aprice. Elementary/Secondary (0-12) College (1-4or 5+) 00 K 10 th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Fown, State, Zip Code) catrice Informant's Name/Relationship (Type, Print) eming Road Wa 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State hapel Cem. -18-06 HOTN TOWN 4 Donation 5 Other (Specify) 22 Name and Address of Facility Bernie Smith Funeral Horo 21. Signature of Funeral Service Licensee 1.0. Box 331 POCOMOKO City, no. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acquired Immune Deficiency Pnysician **IMedical** Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 含 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 No or Attending Physicien: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mannar of Death Certification: Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20063253 3-12-06 C. Eract bill 4.0

DHMH 17 Rev 1/2001

State

Registrar

DN-3

M.D.

1R

egistrar's Signature

Market Street Snow Hill, md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. ERHEST

MAR 1 4 2006

31. Date filed (Month, Day, Year)

ELIJAH JONES 06-01748 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dhysisi		1. [	Decedent's Name	e (First, Middle, L	ast)							2. Date of Dea	ath		3. Time o	
Physici			Elijal	a .Tc	nes							March 1	11. <sup>Day</sup>	2006 Yea	6:00	
/Medic Examir			Facility Name (I	f not institution, g pkins Ho	ive street and				4b. City, Town, Baltin		of Death		4c. C	County of De	eath	
Funeral	-		Social Security N		Sex	7. Ag	e (In yrs. la	st birthday)	II Under 1 Year			8. Date of Birt	h Voasl	9. 8	Birthplace (State	
Director			225 42 ual Residence of		<b>₩</b> ⊒₩ 2□	F	67	Yrs.	Months Days	Hours	Min.	(Month, Day Jan 5			Country) /irgini	
r 28a-f show	tor		a. State	10b. County				Town or Lo							10d. Inside C	
or 28s	Director	10€	. Street and Nu	mber				LI CIN	10f. Zip Code				10g. Citize	en of What (	on of What Country?	
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or itsms refree m	Funeral	11.	Marital Status	ied 2□ Married	12. Was Arme	Decedent od Forces? Yes 2 1	Ever in U.S No		Was Decedent of If Yes, specify Cult			offy Yes or No- Rican, etc.)		4. Race - An Black, Wi Specify:	merican tndian, hite, etc.	
permin: Ages is an expense and ages and perminists notes and Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or its any injury or other traumatic event, the Madical Examina once.	d by		3 Widowed	4 Divorced	Year	or Dates:								F	Black	
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Registrar DHMH 17 Rev 1/2001

State

MAR 2 8 2006

32. Pegistrar's Signature

LING LI, 31. Date lited (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 10, **Physician** HILDA M. JOHNSON 2006 4:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□M 2□F XXX Yrs. 220-30-0943 85 March 24,1920 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or itema 23a or 28a-f ehow the Mudical Examiner must be notified at Carroll Maryland Westminster 1 □₩₩ 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 170 East Green Street 21157 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € Deceded of Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housecleaning Domestic other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should be fi of Health and Mental H item 27 ie marked ot Clarence Clenard Costley Agnes Geneva Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie J. Byrd/Daughter 5718 Silk Tree Dr, Riverdale Park, MD 20737 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
eny injury or ot Pages 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State SOUTH CARROLL CREMATION 03/13/2006 Winfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street MMERS-DURBORAW FUNERAL HOME, P.A. Justy + Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COPI Sequentially list conditions, if any, leading to immediate that the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed inding physicien and use es the burial-transit nemia Due to (or as a consequence of) licotine olevendence Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent precent in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificate 1 Yes 2 No 1 Tyes 2 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manne Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Chatural 5 Pending 24 hours after death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospite 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29b. Signature apo 29d. Date signed (Month, Day, Year) WIL Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Raman 13. Kanena 349 Walcalm dure, Westminty 1

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 2006

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Itimore,

P.O. Box 68760.

Division of Vital Records,

Elven & frank

32. Registrar's Signature

			For 1 = State Registrer	State of M	arylan		artmei <i>rtifica</i>					giene Reg. No.	106	09511
			1. Decedent's Name (First, Middle	, Last)							2. Date of De		Vass	3. Time of Death
н	Physici		STEVEN	DOUGLAS		JOH	ES				MARCI	4 09.	2006	15:27 M
>	/Medio Examin		4a. Facility Name (If not institution	, give street and number)			4b. City	Town, or	Location	of Death	.,	4c. Cou	inty of Deat	h
			THE JOHNS HON	okiNS HO.	SP 4	46	DA	1tin	DRE	Ci	+1			
	Funeral		5. Social Security Number		e (in yrs.	last birthday,	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birt	hplace (State or Foreign untry)
	Director		273-46-4940	1 <b>X</b> M 2□ F	56	Yrs.						5, 195	HO C	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits
	faryli sho	ក		ADIMBET										1 ☐ Yes 2 X No
	28a-1	ect	MD ANNE ANNE A	ARUNDEL	) SE	VERNA		p Code				10g. Citizen	of What Co	unto?
	with	5	368 MAGOTHY RO	A.D.				146				USA		,
	within 72 hours after death with the Maryland ene. ttan "natural", or items 23s or 28s-f show he Madisal Examiner must be notified a	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13.			ispanic Ori	igin? (Spe	cify Yes or No		Race - Ame	rican Indian,
<b>'</b> 0	r Ren	표	1 ☐ Never Married 2 🗶 Marr	Armed Forces			If Yes, spe	cify Cuba	ın, Mexicar	n, Puerto I	Rican, etc.)		e, etc.	
8	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 <b>X</b> I No	Specify:			Spi	ecify:	WHITE
21215-0036	2 ho	Completed	15. Decedent (Specify only highes	's Education			dent's Usi			t of working	20	16b. Kind o	of Business/	Industry
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7	filed wi Hygien other th	6	12	4		PRES	IDEN	•					LTURE	
ם	d oth	Be	17. Father's Name (First, Middle,	Last)							(First, Middle			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the ferm 23s or 28a-f show item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event. The Medical Examinar must be notified at	၉	FRANCIS STEVEN								ANE WIT			
교	and lam		19a. Informant's Name/Relations				-				Route Numb			
	f and fealth om 27		CERISTINE M. J	OBES/WIFE	20% 5				OAD,		RNA PAI		2114	
0	or of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from State	0	Place of Disp cemetery, cre SAPEAR	matory or	other plac	(ON	- 0	ate	20c. Locati	on - City or	Town, State
Ë	men tant: jury		4 □ Donation 5 □ Other (S		CEN	TER, 1	LC.				/2006	STEVE	NSVIL	LE, MD
Baltimore,	permit. Pages : Depertment of h important: If its any injury or ot once.		21. Signature of Funeral Service	Licensee	16	► A	DAMS NNAP	FUNE	RAL 8	CRE 2140		CARE,	814 I	BESTGATE RD.
1	Physician /Medical Examiner	ıl Examiner	23a. Pant1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CARD	AC a conseq a conseq	uence of):	IURE PAR	de of dyin	g, such as	OM 4	respiratory a	rrest,		Approximate Interval Between Onset and Death 17 DAYS
P.O. Box 687	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 ☐ Feta t time of d	il death 31 feath 51	□Ectopic   □ Other (s	pecify)			23a Did		Date of dei	ivery Day Year  the cause of death?
rds,	w requires to been signer should be compared		Tatti. Otto Symiosis octobri		Jul 1101 100	aking in the t	and onlying	oduse giv	on arr arr			Yes 2□N		obably 4 Unknown
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ita,	Physician: this certific ral director, I	Be	25. Was case referred to medical examiner?						26. Plac	e of Death	(Check only	one)		
<u></u>	hysic his co	2	1 ☐ Yes 2 X No	Hospital: 1 Inpati	ent 2	ER/Outpatie	ent 3 🗆 🗅		4 🗆 🖂	ursing Hor	ne 5□Resi	idence 6	Other (Spe	city)
0	ng P		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Inj (Month, Da	ury ly Year)	28b. Time o Injury	of	28c. Injur Wor	y at k?	2	28d. Describe	how injury or	curred	
<u>S</u>	Attending in death. ector: After by the fune	atl	2 Accident investig	gation			М	10	Yes 2	No				
ĎΖ	af or Att	Certification:	3 ☐ Suicide 6 ☐ Could a determ		jury - At h tc. (Specif	ome, farm, si fy)	treet, facto	ry, office		3		Street and N wn, State)	umber or Ri	ural Route Number,
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man and manner stated.						d manner as	s stated. s to the cause(s)					
	To the within 2 To the complet	Me	29b. Signature and title of certifie	d.	. 1		2	c. Licens	e number			29d. Date si	gned (Mont	h, Day, Year)
	> = 0		Valle	M	//.			RES	- 11	20		MADE	IH M	7 2006
	10		30. Name and addres a erson	who completed cause of	death (Iter	m 23a) (Type	, Print)	100	i.c			FINC		1000
-	CIC		Eric J. H	anh M	D.	,600	11. 111	IFE	St	BAH	MARE	MAR	VLANIT	9, 2006
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	7	ature	<u>- 200</u>	1 -	<del></del>		1111110	/ /	-12-21-42	
	Regist		MAR	1 3 2006 b	Palesz	. K	Ana	Les .						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1820 3 Leonard M. Jones, Sr. 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NICOMICO MALCA Salishum TENINSULA REGION DI If Undar 1 Year | If Under 24 Ars. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. 1⊠M 2□F Yrs. Maryland Director 220-26-2044 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count or 28a-f show ul Hygiene. . other than "netural", or Itama 23a or 28a-f shov vant, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Mardela Springs Wicomico Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8365 Hurleys Neck Road 21837 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 弘 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner / Operator Plumbing & Heating 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any july or other traumatic avant 2008: Be Francis Levin Jones Nellie Mae Darby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8365 Hurleys Neck Road Mardela Springs, MD 21837 Barbara S. Jones (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 13, 2006 Hebron, Maryland Hebron Cemetery 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee Per 13 East Grove St. Delmar, DE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physicien and deetached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed: certificete 2□ No 2 LNO 1 TYes 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3113/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. CAMOII ST. 100 CHIPS SNYDEr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2006 Registrar

		4	1 - State of Maryland / Depar Registrar Certif	tment of Health and Mer ficate of Death	ntal Hygiene Reg. No	UUb UJJIJ
2	* * **	0 107	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Da	y Year 3. Time of Death
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)	Examin		4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of Death	4c	County of Death
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	Funeral		5. Social Sociality Hamber	If Under 1 Year If Under 24 Hrs. 8. Wonths Days Hours Min.	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
3	Director		214-07-4747 1 99 Yrs.	NO	ov. 11,19	06 WEST VIRGINIA
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	Mary 1 sh	to	MD ALLEGANY LAVALE			1 ☐ Yes 2X No
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	h with	D E	1134½ BRADDOCK ROAD	21502	U	.S.A.
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Maryland	D = U =	To Be	ISAAC ELIAS LEWIS	CLARA R	EBECCA S	MITH
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	and 2 Balth an 7 27 is		DORIS JEAN WARREN / DAUGHTER 1134	BRADDOCK ROAD, LA	VALE, MD	21502
ē,	f Her item othe		20a. Method of Disposition 20b. Place of Disposition cemetery, crema	ion (Name of Date tory or other place)	20c. L	ocation - City or Town, State
Ë	Pages nent of int: if it		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  GREENMOUNT		2006 C	CUMBERLAND, MD
Baltimore,	그 문문을		21. Signature of Funeral Service Vice see 22.	Name and Address of Facility	OVE D 3	
m	Depa Impo sny ir		Yourd II, tychure	UPCHURCH FUNERAL H 202 GREENE STREET,	CUMBERLA	AND, MD 21502
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9 x	death certific e attending pl id for use as t	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atter d for (	ciar	In the past 12 months?  1 Vos 2 Miles  4 Pregnant at time of death 5	ctopic pregnancy Other (specify)		Month Day Year
P.O.	y th	hysi	9 Unknown			
	law requires that es been signed b 2 should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	v require been sig should b		obstruction of Rt. Subclar	rian Artery	1 ☐ Yes 2	2 No 3 Probably 4 ©Unknown
S	law requ ss been 2 shout	piet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	ician: The la certificete hes rector, page 2	Completed			performed?	death?
ita	certifice rector, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (C		
<b>&gt;</b>	Physician: rthis certific ral director,	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		5 Residence	6 Other (Specify)
0			27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	Work?	I. Describe how inju	ury occurred
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	(0)	
Division of Vital Records,	i or Attena after deatl Director: I in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	City or Town, Stat	and Number or Rural Route Number, te)
	pital ours a eral [	O	29a Certifier 1 X Certifying Physician: To the best of my knowledge, death	recovered and they because of the second reference and	Litus to the enumble	e) and meener as stated
	To the Hospital or At wi hin 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only one) and manner stated.			
	o the	Ne Ne	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			I wonsockshin MD	000553	15 M	larch 04, 2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)		
	30		LENSOCIC SHEN MD 48 TAUN 7	enece Frostbur	a MD:	2 532
3	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	en ce Frosthun	Ü	
2	Regist	rar	MARIO J ZUUD JOSES JO AG	880		

			State of Maryland / [	Departm Certific			and Mer		6000	09514
			1 - State Registrar	Certific	ale of L	Jean	12	Res	g. No.	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)					Month	Day Year	
	/Medic		He/best Schuy or Kline  4a. Fecility Name (If not institution, give street and number)	4h (	City, Town, or	Location		53 1	1 Zoo 6	
	Examin	ier			estmi				(arol	
-	Consent		6. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday) If Ui	nder 1 Year	If Under	24 Hrs. 8.	Date of Birth	9. Bi	rthplace (State or Foreign
	Funeral Director		1×10 - 10 - 1×10 - 1	Yrs. Mon	ths Days	Hours	Min. 0	(Month, Day, 17)	, 1926 Pe	nnsylvania
	ס		Usual Residence of Decedent							
	ıryları show	L.,	10a. State 10b. County 10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	Be-f s	cto	Maryland Carroll		w Wind	dsor				
	vith th	Directo	10e. Street and Number	10f	Zip Code			10	g. Citizen of What C	The second secon
	death with the Maryland ms 23s or 28e-f show rmst be notified at	Funeral	2660 Marston Rd.	140 Wee D		1776		. Vac as Na	U.S.A	
	item item	un.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2  Married  1 ★ Yes 2 □ No	If Yes,	specify Cuba	n, Mexican	i, Puerto Ric	Yes or No- an, etc.)	Black, Wh	
5	urs af	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1948-68	1 □ Ye	s 2 No	Specify:			Specify: W	hite
5-0036	2 hou		15. Decedent's Education 16a.	. Decedent's	Jsual Occupa	ation		1	6b. Kind of Busines:	s/Industry
7	hin 7	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	lite. DO NO	t work done d T use retired	()				
Z	ad with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	mili	tary o	caree	r		U.S. Nav	У
	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)			18. Mothe			aiden Sumame)	
<u>X</u>	ould to Ment arke	ပ္	Herbert O. Kline					et Dic	<u> </u>	
Maryland	2 sh and is m								City or Town, State,	
a)	1 and Health em 27 ther t			2660 Ma			New		r, MD 217 0c. Location - City o	
و	iges if ite or of			of Disposition ory, crematory				741		
Бант	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		' 4 □ Donation 5 □ Other (Specify) All CO	ounty (					ykesville neral Hom	
g	permi Depa Impo any i		Vathania Xanteler		Churc				neral nom or, MD 21	
	-		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or hear failure. List only one cause on each line.							Approximate
	Physician :		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence	of):	rench	age				6 hours
	Examiner		Sequentially list conditions b.			100				
P.	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):						
	acute and trans	Examiner	that initiated events c.							
ρĊ,	ate be executed thysician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence	or):						
9/80	certificate be executed iding physician and ise as the burial-transit	edlo	d						7.	
×	certif iding	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy						23d. Date of de	alivery
nox	death ie atten ad for u	clar	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  25b. Was decedent pregnant in the past 12 months?  4 ☐ Pregnant at time of death		ic pregnancy (specify)				Month	Day Year
j.	the sy the	Physician/M	9 Unknown							
J.	w requires that the been signed by the should be detache	by P	Part II. Other significent conditions contributing to death but not resulting in	in the underlyi	ng cause give	en in Part I.		23e. Did toba	acco use contribute	to the cause of death?
ecords,	en sig		hypertension	· · · · · · · · · · · · · · · · · · ·				1 🗆 Yes	5 2 XNo 3 □ F	robably 4 Unknown
ည	> 0 0	ompleted						24a. Was an autopsy		autopsy findings available completion of cause of
r	The ate has page	Com						perform		
Vital	Physician: The lav this certificate has ral director, page 2	Be (	25. Was case referred to medical examiner?				of Death (C	heck only one	)	
0	Physic this cral dire	은	1 ☐ Yes 2 No Hospital: 1 ☑Inpatient 2 ☐ ER/Ou		DOA Othe	4 🗀 140			nce 6 Other (Sp	ecify)
	Jing P. After I	lon:	Natural 5 Pending (Month, Day Year)	Time of Injury	28c. Injury Work			I. Describe hov	v injury occurred	
UNISION	death death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa	M atract to		Yes 2		Location /Stre	et and Number or F	Rural Pouta Number
2	lor A after Direction by	ertification;	4 Homicide determined building, etc. (Specify)	aim, stieet, ia	dory, office		20	City or Town,	State)	iorai riodio riomoci,
	spita nours neral / filled	O	29a. Certifier r Certifying Physicien: To the best of my knowledge							
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only one)  2 Medical Exeminer: On the basis of examination an and manner stated.	nd/or investiga	tion, in my o	pinion, dea	th occurred	at the time, dat	te and place, and du	ie to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c. License	e number		29	d. Date signed (Mor	nth, Day, Year)
	WIL		· Kweishage 110		MD	D006	2975		3/11/06	
	15		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)					ter, MI	
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	2 Hve	#3	07 1	NEST	mins	zer, MI	21157
	Sta Registr			X See	. 100					
	3.0.		ILILIVIT TA COMO TOTAL TO	- /4						

			For State Registrar	tate of Maryl		artment of H			giene Reg. No:	06	09515
F 3	in the		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic	_	JANICE KATHERIN		DDEN			o3	06	06	7:00 AM
	Examin		4a. Facility Name (If not institution, give street		ital	4b. City, Town, or	Location of De	ath	/	ity of Death	
25		-355A	Sacred Hear 5. Social Security Number 6. Sex	T HOSP	yrs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir		J	place (State or Foreign
	Funeral Director		o. 000iai 000aii,	2□ <b>X</b> F 63		Months Days	Hours M	in. (Month, Da MAR • 24	ıy, Year)	Cou	W YORK
1 1 x.			Usual Residence of Decedent		O: -						10d, Inside City Limits
	arylar ahow	_	10a. State 10b. County WV MINERAL	100	RIDGELE						1 ☐ Yes 2X No
	28e-f	ecto	WV MINERAL  10e, Street and Number		KIDOLL	10f. Zip Code			10g. Citizen o	of What Cou	intry?
	Mith Ba or	١	78 BLOCKER STREET			26753			U.S.		,
	death ms 2:	Jera	11 Marital Status 12.	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No	)- 14. R	ace - Ameri lack, White,	
9	or Ite	by Funeral Director	1 ☐ Never Married 2 XX Married	1 ∐Yes 2 XNo If Yes, Give		1 ☐ Yes 2XNo		one moun, ore.,	Spec	cify:	
9	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow ta Masileal Ex., uither man be malified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Door	dent's Usual Dccup			16b. Kind of	W	HITE
ή	in 72 in 72 in mat	olete	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give	kind of work done of DO NOT use retired	durina most of v	working	TOD. KING OF	Dusinessiii	ladistry
21215-0036		Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	SE	CRETARY			CONS	TRUCT	ION
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)					lame (First, Middle LOUISE (		ame)	
yla		To	IRVING ALTHOUSE							- Canas 7	i- Cordol
Maryland	s 1 and 2 should f Health and Men Item 27 Is marks other traumatic		19a. Informant's Name/Relationship (Type, RONALD B. McFADDEN			ing Address (Street 6			26753	m, State, Zi	p Code)
	Heali Heali tem 2		20a. Method of Disposition		Ob. Place of Disp		and I	Date	20c. Locatio	n - City or T	own, State
<u>o</u> E	Pages iment of tant: If It		1.⊠ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		matory or other place BURIAL 1		/08/2006	CUM	BERLAI	ND, MD
Baltimore,	Departm Departm Importal any inju		21. Signature of Funeral Service Licensee		2	2. Name and Addre	ss of Facility A	L HOME, F	.A.		
<u>m</u>	8828		Grand the ty	pcheuc		202 GREE	NE STRE	ET, CUMBE	ERLAND,	MD 2	
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the ause on each line.	death. Do not er	iter the mode of dyir	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Carcer	of b	reast	with	prepa	STRS	(2)	727 Wy
22	Examiner			Due to (or as a cor	nsequence of):	0.00	U	0/201	D (1)	,	•
ž		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	n uc	10	CINDA	7201		
	cuted od ransit	Examin	that initiated events								
, 00	te be executed ysician and ne buriat-transit		resulting in death) Last	Due to (or as a co	nsequence of):						
68760	₹ × 9	dicai	d								
9 X	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE: 23c. Was decedent pregnant 23c.	ff yes, outcome of pr					23d. i	Date of deliv	very
Box.	death e atter d for u	iciar	in the past 12 months?	1☐Live birth 2 ☐ 4☐Pregnant at time		□Ectopic pregnancy □ Other (specify) _	/			Month	Day Year
P.0.		hys	9 Unknown	9□ Unknown					_		
Ś	The law requires that the ate has been signed by th bage 2 should be detache	by F	Part II. Other significant conditions contri-	outing to death but no	t resulting in the	underlying cause giv	ren in Part I.		tobacco use co Yes 2 □ No		the cause of death?
Record	v requir been s should	Completed						-	T		
3ec	The law ate has b page 2 sl	mple						24a. Was		prior to o death?	topsy findings available ompletion of cause of
a			25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only	2 2 No	1 🗆 Yes	2□ No
Vital	Physician: r this certific ral director,	o Be	evaminer?	pital:	2 ER/Outpatie	ent 3 DOA Oth	ar.	g Home 5 ☐ Res		Other (Spec	cify)
ıοί	ding Phy h. After thi funeral o	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury	of 28c. Injur	ry at	28d. Describe	how injury occ	curred	
sior	Attending r death. ector: After by the fune	catho	2 Accident investigation			M 1	Yes 2 □ No				
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s pecify)	treet, factory, office			(Street and Nu own, State)	mber or Ru	ral Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in 3y the fu		29a. Certifier 15 Certifying Physic	ian: To the best of m	v knowledne dea	ith occurred at the ti	me date and pl	ace, and due to the	cause(s) and	manner as	stated.
	• Hos 24 h	Medicai	(Check only 2 Medical Examiner one)	On the basis of exa and manner stated.	imination and/or i	nvestigation, in my o	opinion, death o	ccurred at the time	, date and place	e, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and tipe of certifier			29c. Licens		0 0	29d. Date sig		
	5		John Me	Mala	CO 14	-0 (4)	-175	16	March	6,	0006
	mes			oleted cause of death	(Maril 23a)	Print)	· C	26 mberia	IN AL	0 3	2502
3	,,		31 Date filed (Month Day Year)	32 Registrar's	Signature	N DKI	me Ce	i i Cei ui	~ ~ ( ) ~	3	-1000
	St Regist	ate rar	MAR 0 9 2006	A Sasa		and?					

			For State Registrar	State of Maryland		artment of F			iene og. No. 006	09516
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic	al .	Earl Walter Matlo					March 4	, 2006	10:30 P M
)	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	ıth
			Lorien Nursing Hor  5. Social Security Number 6. Se		ast hirthday)	Mount .		8. Date of Birth	Carroll	thplace (State or Foreign
Н	Funeral Director			©M 2□F 86	Yrs.	Months Days	Hours Min.	June 29,	Year) C	ountry) rginia
	-		Usual Residence of Decedent					,		
	ahow 1 at	_	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f s	cto	Maryland Freder	ick Mo	nrovia				0.00	
	with th	Funeral Director	10e. Street and Number	1		10f. Zip Code	770		0g. Citizen of What C	•
	9ath 1	eral	4114 Lynn Burke Ro	12. Was Decedent Ever in U.S	5. 13.		770 Tispanic Origin? (Sp		United Sta	
	fer d	Ē	1 □ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whi	
036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f show Ita Madeal Examinar must be motified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup	oation during most of work d)	ring	16b. Kind of Business	/Industry
7	Athin han	d H	Elementary/Secondary (0-12)	College (1-4or 5+)						0
2	filed v Hygie other t ent, th	ပိ	17. Father's Name (First, Middle, Last)	2	Puro	chasing A	18. Mother's Nam		Jibrary of Maiden Sumame)	Congress
anc	t be f	Be c	Marion Abraham Ma	tlock			Josie K			
<u></u>	should and Men marke	၉	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street			City or Town, State,	Zip Code)
	alth ar 27 is r trau		Robert Matlock /	Son	4114	4 Lvnn Bu	rke Rd. M	onrovia.	MD 21770	
ē,	of Health item 27   other tra		20a. Method of Disposition	20b. Pl	ace of Dispermetery, cre	osition (Name of matory or other plan	ce) March		20c. Location - City of	Town, State
Ĕ	Pages nent of I nnt: If it ury or o		1 Strain 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify	Hemovai irom State		Mem. Gard			rederick,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23a or 28a-f show amy injury or other traumatic event, the Modest Examinational be notified at an once.	ĺ	21. Signature of Funeral Service Licen	\$80	2	2. Name and Addre	ess of Facility Funeral	Services	s. Skkot Co	ndy P.A.
<u> </u>	89 E 29		1///		3	501 Cato	ctin Mtn.	Hwy. Fr	s, Skkot Co rederick, I	
			23a. Part. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death one cause on each line.	. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Pneumonia						
	/Medical Examiner		Joseph Joseph	Due to (or as a consequ						<b>4</b> . În
		- G	Sequentially list conditions, if any, leading to immediate	b. Failure to T	ience of):					months
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Anorexia						months
ó	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cal	(	d Hypertension						vears
9	artifica ing pt e as th	Physician/Med	IF FEMALE:	and the second second second			***			
Вох	death certifica attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
0	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify)				
٥.	Physician: The law requires that the de r this certificate has been signed by the a ral director, page 2 should be detached		Part II. Other significant conditions c	ontributing to death but not resu	alting in the	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
Sp	puires n sign	d by	Benign Prostate Hy	ypertrophy, Pa	rkinso	on's Dise	ase,	1 □ Ye	es 2 ⊠No 3 🗆 F	robably 4 Unknown
Records,	s been si should t	Completed	Cerebral Vascular	Accident. Den	ressio	n. Renal	Isuffic-	24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
Re	The la te ha	E						autops perforr	ned?   death?	s 2 No
ita	ian: rrifica stor, p	Be C	iencies, Narcoleps 25. Was case referred to medical examiner?	sy, urinary ir	act II	irection_	26. Place of Dea	th (Check only on	18)	
of Vital	hysic his ce I dire	일	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐		III 3 DON			ence 6 Other (Sp	ecify)
	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	ow injury occurred	
sio	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		me farm s		Yes 2□No	28f. Location (Si	treet and Number or F	Rural Route Number.
Division	P 2	Certification:	4 ☐ Homicide determined	building, etc. (Specify	()	rest, factory, office		City or Town	n, State)	
	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	a C	29a. Certifier 1X Certifying Ph	ysician: To the best of my kno	wledge, dea	th occurred at the ti	ime, date and place,	and due to the c	ause(s) and manner a	as stated.
	n 24 h	edical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	tion and/or it	nvestigation, in my	opinion, death occur	rred at the time, d	ate and place, and du	ie to the cause(s)
	To th withir To th	ž	29b. Signature and title of certifier	1) . 11		29c. Licens	se number	2	9d. Date signed (Mor	nth. Day, Year)
}	-		Ullen	Kerll	1/10		4749	1	March 7, 2	006
	5		30. Name and address of person who	· ·	,					
			Allen Reilly, M.D 31. Date filed (Month, Day, Year)	32 Bagie ar's Signa	e Ave		D, Freder	cick, MD	21701	
	Sta	ate	MAD 1	32. Regis ar's Signa	. #	Soule				

				State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 6 0 9 5 1 7
				negistrar
		Physicia /Medic		ROY CLEMENT MUELLER  Month Day Year  March 12 2006 1:50 AM
		Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	94		ă	Wicomico Nursing Home Salisbury Wicomico
		Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Months Days Hours Min. (Month, Day, Year)  9. Birthplace State or Foreign (Month, Day, Year)
	ш	Director		370-30-0007
		and w	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
		sho ed al	5	MD WICOMICO EDEN
		within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Modical Examities must be modified at	Director	10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?
		with a or		4970 CAMPGROUND ROAD 21822 USA
2		eath	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
EI		ter d	Fu	1 Nover Married 2/V Married 1 Ves W No
7	39	urs a	by	if Yes, Give 1 □ Yes 2 ☒No Specify: Specify: WHITE  3 □ Widowed 4 □ Divorced Year or Dates:
7	ŏ	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry  (Specify only highest grade completed) (Give kind of work done during most of working
101	215	hin 7	ple	Elementary/Secondary (0-12) College (1-4or 5+)
1/2	21	d wit	Completed	12 INDUSTRIAL SCREEN PRINTER PRINT SHOP
MUE	p	al Hy al Hy foth vant	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
5	<u> a</u>	Venta Venta vrked vrked	2	ADAM MUELLER BERTHA LE BLADE
	Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2	≥ .	and eaith n 27		GAIL MUELLER - SPOUSE 4970 CAMPGROUND ROAD EDEN, MARYLAND 21822  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
0	ore	of Ho		Method visposition 3 Removal from State cemetery, crematory or other place)
8	Ĕ	Pag ment ant: I		`4 □Donation 5 □Other (Specify) SILOAM CEMETERY 03-15-2006 SILOAM, MARYLAND
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Marical Examination untilled at ones.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility BOUNDS FUNERAL HOME, INC.  705 EAST MAIN STREET, SALISBURY, MARYLAND 21804
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
_		Physician		Immediate Cause (Final
	7	/Medical		disease or condition resulting in death)  a. Dug to (or as a consequence of):
		Examiner		PNEUMONIA
		* *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
		ate be executed nysician and he burial-transit	Examiner	that initiated events c.
	Ó,	be execuician and burial-tra		resulting in death) Last  Due to (or as a consequence of):
	P.O. Box 68760,	ate bu hysic ihe bu	ical	d
	39	artifica ing pl	Med	IF FEMALE:
	30	ath ce ttendi	an/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
	. E	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as th	Physician/Medi	1   Yes   2 minutes?   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9
	P.0	d by tetach	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
	S,	res th	by	RENAL FAILURE.  1 Yes VINO 3 Probably 4 Unknown
	orc	requi	ted	And the Management findings available
	Division of Vital Records,	law nasb e2st	Completed by	ADVANGO PARKINSON'S DISEASE 24a. Was an autopsy findings available prior to completion of cause of death?
	=	icien; The lav certificate has rector, page 2 :	Ö	1 Yes 2 No 1 Yes 2 No
	/ita	icien sertifi ector	Be	25. Was case referred to medical examiner?  Hospital: Other: Other: Other: A Control of the cont
	of	hysi this c	2	1   res   No 1   Inpatient 2   EMOutpatient 3   DOA   Service   Se
	L C	ling F	on	Natural 5 Pending (Month, Day Year) Injury Work?  Injury Work?  Injury Work?
	Sic	Itend death tor; the	icat	2 Accident A
	Σ	or A after Dirac in by	Certification;	4 Homicide determined building, etc. (Specify)
	i mail	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
		24 h 24 h Fur etely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		ompl	Σe	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		F > F 0		DOD43199 3.13.06
		1.	2	30. Name in address of person who completed cause of death (Item 23a) (Type, Print)
		lik		Yogesh Vohra M.D. 614 Easternshore Dr. Salisbury, Md. 21804
		St	ate	
	<i>y</i> .	Regist		MAR 1 4 2006  MAR 1 4 2006  MAR 1 4 2006
	DH		2001	No Market

ORIGINAL

		•	For State Registrar	State of Maryland /		rtment of H			ne No.006	09518
	Physici	an	1. Decedent's Name (First, Middle, Last)  Dennis Lloyd	Pruitt				2. Date of Death Month March	Day Yea 12 200	3. Time of Death 6 8:42P M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat		4c. County of De	
	LAdillii	۲. په	117 Polaris Driv				ersville		Fred	derick
Say.	Funeral	Ť	5. Social Security Number 6. Sec	5		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y	ear) 9. E	Birthplace (State or Foreign Country)
Se .	Director		21/-52-1/88	55	Yrs.			June 20,	1950 N	Maryland
	and	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	f aho	ō	Maryland Freder	ick		Walkersy	/ille			1X∑Yes 2 ☐ No
	the	rec	10e. Street and Number			10f. Zip Code		109	. Citizen of What	Country?
	h with	Funeral Director	117 Polaris Driv	'e		2	1793		U.S.A	١.
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itema 23e or 28e-f ahow event, the Medical Examinar must be notified at	by Fu	1 Never Married 2X Married 3 Widowed 4 Divorced	1  Yes 2 <b>∑</b> No If Yes, Give Year or Dates:			Specify:		Specify:	White
21215-0036	tural'	d be	15. Decedent's Edu	1	Sa. Dece	dent's Usual Occupa	ation	16	b. Kind of Busine	
5	in 72 an 'r	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	unty	,
212	filed within Hygiene. other than " ant, the Me	E o	Elementary/Secondary (0-12)	College (1-4or 5+) 2 p	olic	eman/ bus	iness ma		ov t./de	ental office
	e file al Hyg othe vant,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
<u>Ja</u>		10	Harold Pruitt					or Davis		
Maryland	2 sho	1 3	19a. Informant's Name/Relationship (T)			_		ural Route Number, C		
ď.	s 1 and 2 should f Health and Mer ltem 27 is marks othar traumatic		Marlene E. Pruitt/ 20a. Method of Disposition	20b. Place	of Dispo	sition (Name of		Kersville,	MD 21/5	
Baltimore,	nt of h		1 ØBurial 2 ☐ Cremation 3 ☐ F	Removal from State ceme	itery, crei	natory or other plac	1		ŕ	
Ē	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		eter	'S Lemete Name and Addres	s of Facility	6/2006 <u>L</u> rtzler Fun	oral Hom	own, MD
Ba	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		Tharine .	Warther		1802 Libe			town, MC	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the death. D						Approximate Interval Between
	Physician		Immediate Cause (Final	_		.1 (				Onset and Death
10	/Medical		disease or condition resulting in death)	a. Esopha Due to (or as a consequence	ce of):	21 - 2				
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	and I-trans	Examiner	that initiated events resulting in death) Last	c	ce of):					
8760,	sicien and burial-translt									
687	ficate I physics the b	odlc		d						
Box	eath certifica attending ph I for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		Tetopio processos			23d. Date of	
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the a detached t	hys	9 Unknown					an Ditte		- to the server of death?
	90 De	þ	Part II. Dther significant conditions co	ntributing to death but not resulting	g in the u	nderlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Unknown
Records,	v requir been s should	Completed								
ec	has b	Jq.						24a. Was an autopsy performe	prior deat	autopsy findings available to completion of cause of h?
a	ate pag							1 ☐ Yes 2	2No 1□	Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	(Outnatio	nt 3 DOA Oth		ath <i>(Check only</i> one) Home 5. Residen		Specify)
of	를 들 글	n: To	27. Manner of Death		b. Time o			28d. Describe how		
ion	Attending or death.	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	mjury		Yes 2 ☐ No			
Division	or Attender de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, st	reet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
	urs af urs af ural D			1					(a) and mann	or an atatod
	Hospital 24 hours a Funeral I	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, deal and/or in	n occurred at the tir ivestigation, in my o	ne, date and plac pinion, death occ	e, and due to the cat surred at the time, dat	e and place, and	due to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	gira mainioi siatou.		29c. Licens	e number	29	d. Date signed (M	fonth, Day, Year)
	1		M. ch. 01	erner M.O		Doo	41619	0	Narch	13, 2003
	MJE		30. Name and address of person who o	completed cause of death (Item 23	a) (Type	Print)	·		04500	
_	10		Michael Lerner	63 Thoma	as Jo	ohnson Dr	. Fred	erick, MD	21702	
8		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		1. "				
	Regist	rar	mAn 14	LUUD JUSTICE J	G.	WAS CO				

		•	For Amend It	State of Ma em 29d per	Dr., G8	eparti Certif	ment of H 3/28/060 icate of L	ealth and I <b>hb</b> Death	d Mental H	ygien Reg. N	<b>2</b> 006	0951	9
	Dhusisi		1. Decedent's Name (First, Middle, Las						2. Date of Month		ay Year	3. Time of Dea	
	Physici: /Medic			Dliver	Piper	-	C: T		MARCH	14	2006	1305	М
	Examin	er	4a. Facility Name (If not institution, give MEMORIAL HOSP)			41	b. City, Town, or CUMBERL		eath	4	c. County of Dea		
	Funeral		5. Social Security Number 6. S		(In yrs. last birth		f Under 1 Year	If Under 24 I	Hrs. 8. Date of	Birth	9. Bi	rthplace (State or Fo	reign
	Director		217-54-6759	<sup>⊠M 2□F</sup> 5	5 Y	rs. M	lonths Days	Hours N	Nov	23,11	950	ou <mark>MTD</mark>	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locati	ion					10d. Inside City Li	imits
	Maryle f eho	ŏ	MD Allegar	ny	Cu	mbe	rland					1 <b>√</b> Yes 2 □	] No
	r 28a-	rect	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What C	country?	
	be filed within 72 hours after death with the Marylend Ital Hyglene I do ther than "natural", or items 23a or 28a-f ehow event, the Madical Examiner must be putified a	Funeral Director	12613 Limestone	Road SE			2	21502			USA		
	ems ems	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was	s Decedent of His es, specify Cubar	spanic Origin' n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am Black, Wh		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 🗆	Yes 2 No	Specify:			Specify: W	nite	
00	ture!	ed b	15. Decedent's Ed	L	16a. [	Decedent	t's Usual Occupa	ition		16b.	Kind of Busines		
212	within 72 ene. than "ne he Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5			d of work done d NOT use retired;	uring most of	working	_		1 - 6 1	
7	filed with Hygiene. other than	Com	12		" labo	rer						hest Inc.	
pu	be file of oth	Be	17. Father's Name (First, Middle, Last)  David Oliver Pip						M. Butts		,		
ry la	2 should be and Mental is marked o	ဥ	19a. Informant's Name/Relationship (		19b.	Mailing A	Address (Street a					Zip Code)	
Z	D € 5 €		Viola Piper	moth	er 1:	2613	Limesto	one Rd	SE Cur	nberl	and N	/ID 21502	
ore,	ges 1 en it of Heel if Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Dame val from State	20b. Place of I	Disposition, cremate	on (Name of ory or other place	9)	Date		Location - City of		
Ē	Pages ment of ent: If It ury or o		4 □Donation 5 □Other (Specify		Hartsock	Cem	ory or other place netery		3/17/200	O	ldtown	MD	1
Baltimore, Maryland 21215-0036	permit. Page Department of Importent: if any Injury or ance.		21. Signature of Funeral Service Licer	1 A IM	Wi-	22. N			l Home, PA nue: Cumb		ND 215	02	
			23a. Plant Enter the disease, or com	plications that caused	the death. Do no	ot enter t					a, IVID 2 10	Approximate Interval Between	en.
	Physician		Immediate Cause (Final disease or condition	a SEPTIC S								Onset and Dea	
Part I	/Medical		resulting in death)		a consequence o	f):						Z WEEKS	
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	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а солѕедиелсе о	1):							
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9	ntifical ng phy as th	Med	IF FEMALE:		4-70-8-6					*			
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		topic pregnancy				23d. Date of d Month	elivery Day Yea	ır
0.	t the dea by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5∐0	ther (specify)			-			
<u>α</u>	that the ed by detac		Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the unde	erlying cause give	en in Part I.	23e. D	id tobacc	o use contribute	to the cause of deat	th?
rds	quires n sign ald be	d by	CHRONIC OBSTRUCTI	VE PULMONA	RY DISEA	ASE			_ 1	☐ Yes	2 No 3	Probably 4 □Unk	nown
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ita	icien: certifici ector.	Bec	25. Was case referred to medical examiner?						Death (Check or	ly one)			
of \	Physicien: rthis certific ral director.	ဥ	1 □ Yes 2 No	Hospital: 1 X Inpatie		-		4 🗀 (40) 51	ng Home 5□ P		6 □Other (Sp	pecify)	
uc		tion	27. Manner of Death  1 Natural 5 Pending  O Accident investigatio	28a. Date of Injur (Month, Day	ry 28b. Ti y Ye <i>ar)</i> In	ine of	28c. Injun Won M 1	γαι ∢? Yes 2∐No		36 HOW III	ijur <b>y</b> occurred		
Division	if or Attendi after death. Director: A d in by the fu	fical	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, far	m, street			28f. Locatio			Rural Route Number	r,
Ö	s after	Certification:	4  Homicide	building, etc	c. (Specify)				City or	Town, St	are)		
	To the Hospitet or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Medical (	(Check only 2 Medical Example 12	nysician: To the best miner: On the basis of	examination and								
	thin 2 the p the	Med	29b. Signature and title of certifier	and manner sta	100.		29c. License	number		29d. l	Date signed (Mo	nth, Day, Year)	
	F ≯F 8		+ (WIII)	tum m	wO		D2540	16		МАТ	RCH 27.	2006	
			30. Name and address of person who		-	Type, Pri	-				21,		
			WILLIAM LAMM, M.D.				MBERLANI	),MD 21	1502				
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	-	. a						
	Regist	ar	MAR 2 8 200	Menter	# A	13462							

Baltimore, Maryland 21215-0036 COCKOCY, WALBURG-A

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Certification:

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30. Name and address of pe

Funeral

Director

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2 should be filed within 72 hours after on and Mental Hygiene. Is marked othar than "natural", or Iter

Pages 1 and 2 ment of Health a ant: If itam 27 is

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend item 29d per doc 8853 3-28-06 vt

mend item 5 per in 8854 4-28-06 vt Amend item 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MARCH Year 45 pM Walburga Rockocy 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HAURE DE GRACE NURSING HOME HARFORD CITIZENS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day), Hours | Min. Jan. 25, 5. Social Security Number 57 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign , Year 924 Germany Months 1 ☐ M 2 🖫 🕏 F 82 Yrs. 218-54-01<del>56</del>-Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 943 Stepney Road 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Neumeyer Anna Branner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 943 Stepney Road George Rockocy (Spouse) Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State Harford Mem. Gdns. 3/17/06 4 □Donation 5 □ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ecopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 <del>| 1</del>10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar eath (Item 23a) (Type, Print)

cause

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gerald E. Shroyer 06 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY HEART HOSPITAL CUMBERLAND SACRED If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday). 5. Social Security Number 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** 218-30-0188 Yrs. Director 8-7-1933 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ul Hygiene. other than "natural", or iteme 23e or 28e-f show vent, Ite Medical Executant must be notified at MD Allegany Ellerslie 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10155Hummingbird St 21529 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 5 2 ⊷ 7 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military 12 USMC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George W. Shroyer Goldie Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Janis Rowe/ Daughter 6686 Hwy 391 Prosperity, SC 21927 permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tro 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Porter Cemetery 3-9-2006 Hundman, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nemorthou **Physician** in tracetebral 6 houts /Medical Due to (or as a consequence of): Examiner hypret tensive rotalovasculat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has blirector, page 2 s autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \( \triangle \text{Nursing Home} \) 5 \( \triangle \text{Residence} \) 6 \( \triangle \text{Other} \( (Specify) \) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manyler of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours efter death. seral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical th e 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 009031 15

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State Registrar HALEN

32. Pajistrar's Signature

CUMBERLAIND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANCET

31. Date filed (Month Ray Year) 2006

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State of Maryland / Department of Health and Mental Hygiene 09522 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death lonth **Physician** 0515 Sherry Colleen Schade 0 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Alleganu umber If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/09/1961 Age (In vrs. last birthday) Funeral 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days 1 □ M 2 🖺 F Hours Min 45 Director 219-84-6999 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-1 ehow 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 14700 Michael Road 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James С. Willison Betty Alt Willison ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Matthew Dougherty / son 14504 Baltimore Pike, NE., Cumberland, MD 21502 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō Depertment of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 03/09/2006 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Frineral Service Licensee 404 Decatur Street, Cumberland, MD releans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnemonia Immediate Cause (Final Bilateral **Physician** 3 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Iweek Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physiclen and resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown sete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Melastatic Breast Cancar 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy performed? 2 No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) N Inpatient 1 ☐ Yes 2 ☐ No Certification; To 2 ER/Outpatient 3 DOA Ihis 28a. Date of Injury (Month, Day Year) efter death. Director: After th 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58853 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 131 PENNSYLVANIA AVE, CUMBERLAND, MD 21502 HABIB CHOTANI 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carroll County, wjl State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 9.50PM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. S2011364384N9821 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Hours Mary Tand Yrs. 6/ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or items 23a or 28e-f ehow eny injury or other treumatic event, the Madical Examinar mass here. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Carroll Lineboro Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4209 Main St. 21088 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 XNo Specify: Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cook restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Samuel Blacksten Ethel Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alden W. Shaffer Sr./ husband 4209 Main St. Lineboro, MD 21088 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Luth. Cem. 3/15/2006 Uniontown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHartzler Funeral Home attrarine New Windsor, MD 21776 310 Church St. 23a. Part1. Enter the disease, or complications that cau the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner SKD. Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit OME THUE resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ Hypotension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 No 2 No or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lowe Curce Silver Spring mp was 0131 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Amended Item 5 per F.D., Items 23a, Part I, Line a, Part II, & 31 per Physician

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			30. Name and address of person		•			7.								
	~ Sta	to.	Robert Durkin 31. Date filed (Month Day, Year)	32.	B Health Degistrar's Sign	ature			n, MI	218	311					
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Baltimore, Maryland 21215-0036	d within 72 hours after deeth with the Maryland piene. rr then "naturel", or Iteme 23a or 28a-f ehow the Madical Examiner must be notified at	Completed by Fu	1 Never Marri	ied 🏌 Marrie 4 🗆 Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:					Specify				Specify:		white
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ē,			20a. Method of Disp	position			lace of D	isposition (Na	ame of	(0.0	Da	ate	20c.	Location - C	ty or T	own, State
E	Page nent o int: If iry or			☐Cremation 3 5 ☐Other (Spe	I □Removal from State scify)	Tr	init	y Mer	nori	ãl G	ar.3	/24/0	)6 V	Valdo:	rf,	Maryland
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	ineral Service Li	censee M(	0094	5							HOME		
<u>m</u>	89 5 5 8		1 La	is/ C	. Echol			P.0	. BO.	X 56	7. L	A PLA	TA.	MD 20	)64	6
	Physician /Medical		23a. Part1. Enter the shock, or head immediate Cause (disease or condition resulting in death)	(Finat	omplications that caused by one cause on each limited and a cause on each limited and a cause along the cause along the cause on each limited and a cause on each limited	cohol i	intoxi	enter the mo	ode of dyin	ng, such as	s cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner		•	1	Due to (or as	a consequ	uence of)									
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	uted ansit	Examiner	Sequentially list con 1 any, leading to in cause. Enter Unde Cause Obsease or	injury												
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	bur be	_			d.											
68	tiffical ng ph	led													Ш	
XOX	leath certificate be ettending physici I for use as the bu	an/	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth			3 ☐Ectopic	pregnancy	,				23d. Date		,
Э. В	ne dea the ett hed fo	Physician/Medica	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4☐ Pregnant a 9☐ Unknown			5 Other (s						Month	1	Day Year
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Division of Vital Records, P.O. Box 687	se us	ed by	rattii. Otter sigini	icani condition	s contributing to death b	out not resu	uiting an tr	ie underlying	cause giv	en in Part	1.	1				the cause of death? bably 4 Unknown
o O	law requass been 2 should	Completed										24a. Wa		24b. We	re auto	opsy findings available ompletion of cause of
æ	The lay	E										_ perf	opsy formed: 2   1	? dea	or to co ath? ]Yes	2 No
ita	ian: rtifica	Bec	25. Was case refer	red to medical						26. Ptac	e of Death	Check only		10	, 103	20110
<b>&gt;</b>	hysic nis ce I dire	ည	examiner? XXYes 2□	No	Hospital: 1  Inpatie	ent 2 🔯	ER/Outpa	atient 3 🗆 🗅	Oth Oth	er: 4 □ N	ursing Hor	ne 5 ☐ Res	sidence	6 ☐Other	(Speci	fy)
0	ng Pl	ë	27. Manner of Deatl	h 5 🗆 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Tim Inju	ry	28c. Injur Wor	y at k?	2	8d. Describe	how in	jury occurred		
sio	Attending ir death. ector: After by the fune	cat	2 Accident	investiga 6 X Could no	tion Ind 3/18/2	2006 F	nd 6:	40 AM		Yes 2X						
Divi	s after death s after death al Director: , ad in by the f	Certification;	3 Suicide 4 Homicide	determin		iury - At ho ic. <i>(Specify</i>	ome, farm v)	, street, facto	ory, office		1 I	8f. Location City or To a Plata	(Street own, Sta	and Number ate) 15 Po )	or Rur. Coha	al Route Number, ntas Ct.
	Hospi 4 hou Funer tely fill	edical (	29a. Certifier (Check only one)	1☐ Certifying 2XXIIIIII Ex	Physician: To the best caminer: On the basis of and manner st	i examinat	wledge, d	eath occurre	d at the tir	ne, date ai pinion, dea	nd place, a	nd due to the	e cause	(s) and mann	er as s d due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and	title of certifier				25	9c. Licens	e number			29d. (	Date signed (	Month,	Day, Year)
	- > - O		► Wini	140	molla.	00 1	Una		O.C	.M.E.				arch 19		
(	NB		1 4 A . A . C		no completed cause of c		1 23a) (Ty	pe, Print) 1 Penr				more.		yland		201
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	Registra			MAR 2	2 2006	ر میں	H.	Spares	0							

			State of Maryla  1 - State Registrer		nent of He			ene 2006	09526
	9 %		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death
L <sub>3</sub>	Physici /Medic	al	Janet Marie Tull				03-1	0-200	6 1605 M
	Examin		4a Facility Name (If not institution, give street and number)	4b.		Location of Death		4c. County of De	
			5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday) If U	Inder 1 Year	Sbury II Under 24 Hrs.	8. Date of Birth	Wicon	inthplace (State or Foreign
38	Funeral Director	1	221–56–2257 1 M 2 XF 42	Yrs. Mor		Hours Min.	8. Date of Birth (Month, Day, 5/20/196	7ear) 63 Ma	country) ryland
d.	D.		Usual Residence of Decedent						10d. Inside City Limits
	arylan show dat	_	,	City, Town or Location Hebron	1				1 ☐ Yes 2 No
	he Ma	ecto	Maryland Wicomico  10e. Street and Number		f. Zip Code		10	g. Citizen of What	Country?
	with t	늅	27019 S. Tourmaline Dr.		21830	)		USA	
	ns 23	era	11 Marital Status 12. Was Decedent Ever in	n U.S. 13. Was [		spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-		nerican Indian,
9	or ite	Fur	1 Never Married 2 Married 1 Yes 2 No		es XI No	Specify:	riioari, etc./	Specify: W	
8	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Madical Examiner munitie, inditied at	Completed by Funeral Director	3 Widowed 4 Divorced Year or Dates:					16b. Kind of Busine	
15-	n 72 l	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's (Give kind	of work done di OT use retired)	uring most of worki	ing	IOD, KING OF BUSINE	samuustry
12	iene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)  12	Cosmeto	logist			Beauty	
פָׁב	at Hyg at Hyg othe vant.	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name			
ylar	Menta Menta arked	ToE	Wayne Edward Brumbley			June Iri			
Maryland 21215-0036	2 sho and ls m		19a. Informant's Name/Relationship (Type, Print) Samuel E. Tull/husband					City or Town, State	
	1 and Health em 27 ther t		20a Method of Disposition 20	b. Place of Disposition	(Name of			20c. Location - City	
nor	ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	wîcomico M Park	emoriai	"   3/15,	/06	Salisbur	y, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Department of Health and Mentat Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show ampringing or other traumatic event, the Madical Examinatorial traumatic events.	1	21 Signature of Funeral Service Liberates	L. CH	ne and Addres OWAY. Fil	s of Facility Ineral Ho	me Profe		- Association
	40200		23a. Pay 1. Enter the disease, or complication, that caused the d					-	Approximate Interval Between
	Physician		strock, or heart failure. List only one cause on each line.	ATIC API	PENNI	CEAL	CARCIA	10 M A	Onset and Death
1	/Medical		disease or condition resulting in death)  a. /// Due to (or as a con		Cr Ul	CZAL	4110011	101-17-	
0	Examiner		Sequentially list conditions.						
Ş	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):					
	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last  Due to (or as a con	sequence of):					
8760,	sician buria	icai E							
9	ifficate g phy as the	edic							
Вох	eath certific attending p I for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F		pic pregnancy			23d. Date of Month	delivery Day Year
	it the deal by the att tached to	sicia	in the past 12 months?  1  Yes 2  No 9 Unknown 9 Unknown		er (specify)			WORTH	Day 1841
P.O.	law requires that the as been signed by th 2 should be detache		Part II. Other significent conditions contributing to death but not	resulting in the under	ving cause give	en in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?
Records,	signed d be del	d by			, ,		1 □ Y€	s 2 476 3	Probably 4 Unknown
cor	w requir been s should	Completed					24a. Was a	n 24b. Were	autopsy findings available
Re	The lav	шс					autops perform		
Vital	sician: T certificat rector, p	0	25. Was case referred to medical			26. Place of Deat		(	
<u>_</u>	× 0 0	ToB	examiner? 1   Yes   Hospital: 1   Inpatient	2 ER/Outpatient 3	□ DOA Othe	or: 4 🗆 Nursing Ho	ome 5 Reside	ence 6 Dother (S	ipecity) Hospica
n of			27. Manner of Ceath 28a. Date of Injury  Natural 5 ☐ Pending (Month, Day Yea		28c. Injury Work	(?	28d. Describe ho	ow injury occurred	
Sio	Attending r death.	cati	7 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury.	At home, farm, street,		Yes 2 □No	28L Location (St	reet and Number o	Rural Route Number,
Division		Certification;	4 Homicide determined 200. Flace of Injury 1		actory, office		City or Town	n, State)	
	Hospita 4 hours Funeral ely fille	Medical C	29a. Certifier Certifying Physician: To the best of my (Check only one) Medical Examiner: On the basis of examiner stated.	knowledge, death occ mination and/or investi	curred at the tim gation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	vithin 2 within 2 To the complet	Mec	29b. Signature apartitle of certifier		29c. License	number	2	9d. Date signed (M	onth, Day, Year)
	- 2 + 9			2-	00	05841	0	13-11-	06
Į	(10m		30. Name and address of person who completed cause of death	(Item 23a) (Type, Prin	1)				106 102180/
_	<u></u>		GHULAM WARIS 26266	, , ,	WOOD	CT. S	AUSB	ury n	10 2180/
180081	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Pegistrar's S	ignature	<i>N</i> -			,	,
77.5	· regist	- 21	MAR 1 4 2006	It show	121				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** 1650 Katherson Turner R. /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO eninsula legional medical Center If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F Vrs 91 577-24-9935 9/12/1914 Director Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State rthan "neturet", or items 23a or 28a-f ehow the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1110 Healthway Dr. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3

☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiers important; if item 27 is marked other than any injury or other traumeste. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Creighton Rice Mary Kathryn Diffenbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul Turner 6265 Westbury Dr., Salisbury, MD 21801 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 3/24/2006 Adelphia, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that eause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Sailure Physician 12 da /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed physicien and the burial-transif Due to (or as a consequence of): Box 68760. Physician/Medical attending pr IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ COPD, alad Siballation, HISP 1 ☐ Yes 2 ☐No 3 Probably 4 Unknown Completed 63 Blesd. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 Yes 2 2 No 1 🗌 Yes Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funers! Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 26612 2-19.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Crown Hid, 105 Phis Bluff, Siz 7, Sphiloun, MO SIBUL 31. Date filed (Month, Day, Year) 32. Regiştrar's Signature State Registrar MAR 2 8 2006

**ORIGINAL** 

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			1 - For State Registrar	State of Marylar		artment of F		•	giene Reg. No.	006	09529
			1. Decedent's Name (First, Middle, Las	)				2. Date of De		Voor	3. Time of Death
	ysici: Medic		Michael Joser	h Ward				March	Bay	2006	2348 м
	amin		4a. Facility Name (If not institution, give E/B Cedarville Ro	street and number)	Lane	4b. City, Town, or Brandy	r Location of Deat Wine	h		County of Death rince G	
	neral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	(Month, Da	v. Year)	LOU	place (State or Foreign
Dire	ctor		217-04-7971 Usual Residence of Decedent	22_	713.			12-13-	1983	wasn.	'D.C.
land <b>ow</b>	1		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			7		10d. Inside City Limits
Mary ♣	pell	ţŏ	MD. Prince Go	orges Bra	andywin	e					1 ☐ Yes 2 💢 No
r 28s	iboti	Director	10e. Street and Number	501 905	<i>y</i>	10f. Zip Code			10g. Citiz	en of What Cou	intry?
h witl	stke		17311 Dent Rd.			20613			U.S.		
deat	event, the Medical Examinar must be putified at	Funerai	11. Maritat Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	1-	4. Race - Amer Black, White	
after or the	urdra	교	1 X Never Married 2 ☐ Married	1 Tes 2 No		1 ☐ Yes 2 No	Specify:	o raodii, oto.,		•	
nours urai',	Exa	d by	3 Widowed 4 Divorced	Year or Dates:						Specify: Whi	
72 t	adles	Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	rking	16b. Kin	d of Business/II	ndustry
withir than	W W	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ement/Foc			Res	taurant	:
Hygie	ut, m	e Co	17. Father's Name (First, Middle, Last)		Tiuriug	Cincilo/100		ne (First, Middle			
Individed the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	0 A	00		Mandnagos			Joyce A	nn Ward		•	
Shoul M br	mati	우	Stephen King  19a. Informant's Name/Relationship (T	Mandragos ype, Print)	19b. Mailir	ng Address (Street			er, City or	Town, State, Zi	p Code)
end 2: ealth ar	rtra		Stephen Mandragos	/ Father	17315	Dent Rd.	Brandyw	ine Md.	206	13	
S S S S S S S S S S S S S S S S S S S	othe		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date		ation - City or T	own, State
Pages nent of the	ry or		1 🖾 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify	nemoval from State		Epis.Chu	1	5-2006	Croc	m, Mary	/land
pertinicie, ivial y la permit. Pages 1 end 2 should Depertment of Health and Men Importent: if Item 27 is marke	구성		21. Signature of June 1 Service Licens		22	Nome and Addre	cc of Equility				
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	fications that caused the dea							Approximate fnterval Between
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/Med			resulting in death)	Due to (or as a conse							•
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be ey	the burial-transit	E		200 10 (01 23 2 001)301	4201100 01).						
icate	s the	dical		d						1	
certii	пѕе а	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					2:	3d. Date of deliv	rerv
ette des	d for	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		Ectopic pregnancy Other (specify)	<u></u>			Month	Day Year
the y	ached	hys	9 Unknown	9□ Unknown							
s thai	should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
quire on sig	d bi	ed t						10	Yes 2.5⊆	No 3□Pro	babiy 4 Dunknown
aw se	2 sho	Completed						24a. Was		24b. Were aut	opsy findings avaitable
The fa	age 2	E						auto perfo	psy ormed? 2/2 No	death?	omptetion of cause of
vician: Th	director, page	0	25. Was case referred to medical	1111			26. Place of Dea	ath (Check only o	-7505	12.00	20110
ysici is ce	direc	To B	examiner? 1√GYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	nt 3 DOA Oth	er	lome 5⊡Resi		XXOther (Spec	(v) Scene
- 5e ē	neral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c. fnjur Wor	y at k?	28d. Describe		_	Δ
ath.	he fu	Certification:	2 Accident investigation	March 9,2006	11:38		Yes 2 No	passeng	er ou	sho fixe	ed object
r Att	by t	ţţ.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At h building, etc. (Speci	iome, farm, str	eet, factory, office		City or To	wn, State)		al Route Number,
is a f	9			loca	Shee	t		Cedaru	alle R	cod at la	ants lave
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and	completely filled in by the funeral	Medical	(Check only 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin	owledge, death ation and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occu	e, and due to the	cause(s) a	and manner as	stated. to the cause(s)
o the	eldmo	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
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ſ			30. Name and address of person who o	ce out of the company	M 230) /T	OCN Print)	正		narcn	, 10, 2	000
KB7			Taska Z Greense		m ∠oa) (1ype,	•	enn Stree	t Balt	imore	. Marvl	and 21201
م الماس	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign						,	
Re	egistr		MAR 1 4	2006 Keren	B 1	bords					
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			For State Registrar	State of Maryl		partment of F ertificate of a			ene	UJJJU
	Physici		1. Decedent's Name (First, Middle, Last	Harrington	Dykes	Whayland		2. Date of Death Month March	Day Year	3. Time of Death
)	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	<b>-</b>		r Location of Death	L	4c. County of Death	
Ī	Funeral Director		Social Security Number 6. Se		yrs. last birthda Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3/10/19	O Rieb	place (State or Foreign ntry) ryland
	D.		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or	ocation				10d. Inside City Limits
	Many Many	ţ	Maryland Wicomic	:0	Salisb	ıry				1⊠Yes 2 No
	th the or 28s	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	ath wi	rai	1407 W. Sandy Ac				1804		USA	
350	within 72 hours after death with the Maryland iene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marned  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of H II Yes, specify Cuba 1 ☐ Yes 2€ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: wh	
315-0036	in 72 hou n *natura Accical E	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Dec (Giv	edent's Usual Occup re kind of work done DO NOT use retired	pation during most of work d)	ing	16b. Kind of Business/Ir	ndustry
717	filed within Hygiene. Ither than	ШО	Elementary/Secondary (0-12)	College (1-4or 5+)	Ног	nemaker			Domestic	
yland	be at a second	To Be C	17. Father's Name (First, Middle, Last) Charles L. Harri	ngton			18. Mother's Name Ida Pea	e (First, Middle, M arl Jones		
Mary	12 shoh and hand 7 is m	-	19a. Informant's Name/Relationship (T) Cynthia A. Dykes						City or Town, State, Zij Sbury, MD	
Baitimore,	Head Head		20a. Method of Disposition 1 □	Removal from State	Springh Springh Gardens	position (Name of Principles of Memory)			Rebron, M	
Balt	permit. Pages i Department of H Important: If ite eny injury or ot once.		21. Signature of Funeral Sent Licens			22. Name and Addre HOLLOWAY E	funeral Ho	ome Profe Salisbur	essional As Ty, MD 2180	sociation 4
	9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the		nter the mode of dyir	ng, such as cardiac		est,	Approximate Interval Between Onset and Dearts
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a con	nsequence of):	nec	det		ove	month
,	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause from Unioning Cause (Disease or injury that initiated events							
8/60,	ficate be executed physicien and is the burial-transit	dical Examin	that initiated events resulting in death) Last Due to (or as a consequence of):							
вох ря	death certificat e attending phy d for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23d. Date of deliv	rery Day Year					
5.	the c y the	Physician/M	1 ☐ Yes ⊅ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown		Other (specify)				
ecords, I	law requires that as been signed b 2 should be deta	þ	Part II. Other significant conditions co	ontributing to death but no	t resulting in the	underlying cause giv	ven in Part I.	1  Ye	acco use contribute to	bably 4 Unknown
r	o	Completed						24a. Was ar autops perform 1 Yes 2	y prior to co	opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only on	θ)	
0	Physician: r this certific ral director,	၉	1 □ Yes 2 No		2 ER/Outpat	ent 3 DOA		-	nce 6 Other (Speci	fy)
	ing After	inol in	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury	Wo	rk?  Yes 2 □No	28d. Describe ho	w injury occurred	
DIVISION	or Attenutier deall Director: in by the	Certification:	Z		At home, larm, pecify)		1165 2 110	28f. Location (Sti City or Town	reet and Number or Rur , State)	al Route Number,
_	Hospital 4 hours a Funeral tely filled	Medical Ce		vsician: To the best of my iner: On the basis of exa and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0/1		29c. Licens	se number	29	9d. Date signed (Month,	Day, Year)
	NA.		(2)(2)	Mn	20	D	みらみつ	8	3-10-	-06
*	79/m		30. Name and address of person who of Daniel E. Corall, M.	completed cause of death  Coastal Hos		e, Print)	3 Seels	L, M	3-10- MD 7 1662	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 4 2	32. Registrar's	Signature	Sprits		0		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** ORVILLE EDWARD YOUNG MARCH 4 2006 8:47 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CUMBERLAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, AUG. 9, ALLEGANY CUMBERLAND NURSING HOME Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 78 1927 MARYLAND Director 220-16-7150 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other than 'natural' any injury or other traumatic excessions. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1√2Yes 2□No Director MD ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 205 BALTIMORE AVENUE 21502 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give 1X Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates: WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 1Ó PAINTER & MECHANIC AUTOMOBILE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ORVILLE L. YOUNG MILDRED E. MEANS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT YOUNG / BROTHER 600 FREDERICK STREET, CUMBERLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03/08/2006 \* 4 □ Donation 5 □ Other (Specify) M.S.V.C.-ROCKY GAP FLINTSTONE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 202 GREENE STREET, CUMBERLAND, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final Physician andro disease or condition resulting in death) /Medical Due to (or as a consumence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 10 4☐Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 □Unknown 2 No 1 ☐ Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No certificate Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this funeral 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hous. • the Funerel Direc. • ∼lv filled in by 4 🔲 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the I 29c. License number 29b. Signature and title of certified 2 2/10A person who completed cause of death (Item 23a) (Type, Print) Ceraberland, Ad 2150 30. Name and address of 7115 5 10000 Carr 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2006 Registrar

			1 - For State Registrar	State of Maryl	land / Depa	artment of trificate of	Health ar		•	ne n	6	09532
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  MARIE AMA	ruce 1					ate of Death Ionth	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s ESTHER'S PLACE, 28	treet and number)	AUE		LAm	RE		4c. County	/A	
	Funeral Director		5. Social Security Number 6. Sex 215-05-4246	м 2XF 7. Age (In 92	yrs. last birthday) Yrs.	If Under 1 Year Months Days		Min. B. Da	ate of Birth fonth, Day, Ye R 3 19	14	9. Birthp Coun	lace (State or Foreign htry) MD
	Maryland	tor	10a. State 10b. County  MD N/A	10c	City, Town or Lo		·				1	0d. Inside City Limits
	3a or 28a	Il Director	10e. Street and Number 2802 Pinewood Ave	nue		10f. Zip Code 2121	4		10g.	Citizen of	What Coun	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, it a Medical Examinal must be notified at once.	by Funeral (		2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul	Hispanic Origin Dan, Mexican,	n? (Specify Y Puerto Rican	es or No- , etc.)	14. Rad	ce - Americ ck, White,	
Maryland 21215-0036	d within 72 ho jiene. ir than "naturi It e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire STRESS	during most o	of working	C	lothi anufa	ng	
/land	und be file Mental Hyg arkad othe	To Be C	17. Father's Name (First, Middle, Last) Vasile Suciu						t, Middle, Mai Floret		ne)	
, Mar	and 2 sho saith and l n 27 is ma		19a. Informant's Name/Relationship (Type Maria Suciu - sist	er in law	1236	ng Address (Stree Glyndor	. Avenu	e, Bal			State, Zip 2122	_
Baltimore,	Pages 1 ment of Hi ant: If iter iury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Real Donation 5 Other (Specify)	emoval from State	Db. Place of Dispo cemetery, crea hesapeak		1	Date /27/20		eltsv		
Bai	permit Depart Import any inj		21. Signature of Funeral Service License	MO MO	0986 87	FA, Ster 17 Green	<u>Pastu</u>	res Dr	ive, T	owson	, MD	21286
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Due to (or as a cor	uncu	er the mode of dy	ing, such as ca	ardiac or resp	piratory arrest,			Approximate Interval Between Onset and Death
	ificate be executed XX in the physician and XX is the burial-transit CX	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):							
P.O. Box 687	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pro	Fetal death 3	Ectopic pregnand	су				ate of delive	ery Day Year
	quires that n signed by itd be deta	þ	Part II. Other significant conditions con	tributing to death but not	t resulting in the u	nderlying cause g	ven in Part I.	2		co use con	tribute Io th	ne cause of death?
II Reco	The law require sate has been signage 2 should t	Completed	Dement a						24a. Was an autopsy performe ☐ Yes 2/X	3?		psy findings available mpletion of cause of
Division of Vital Records,	Attending Physician: The lav r death. ector: Aler this certificate has by the funeral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	f 28c. Inju	ther: 4 Nurs	28d. E				y nssisted
Divisi	al or Attences after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.		reet, factory, office		28f. L	ocation (Stree City or Town, S	et and Numi State)	ber or Rura	il Roule Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	23 Cartilier   1   Certifying Physical (Check only one)   2   Medical Examination	ician. To the best of my ier: On the basis of exar and manner stated.	knowledge deat mination and/or in	h occurred at the vestigation, in my	opinion, death	place, and di occurred at	the time, date	and place,	and due to	taled o the cause(s)
)	To t To t com	Σ	29b. Signature and title of certifier  Which Klox			29c. Licen	31295	-	29d.	Date signe	ed (Month,	Day, Year)
	5		30. Name and address of person who co		(Item 23a) (Type, HRAUGN	BLVD, 1	20.B =	Duine	208A,	BACT	, M	021239
8	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 9 2006	32. Registrar's S	ignature.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2/0 PM Warren /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center (Genesis Perry Parkway Baltimone
If Under 1 Year | If Under 24 Hrs. Baltmone County 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 1 M 2 □ F 215-40-7728 Yrs. Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event. The Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 HNO Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue U 54 Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Iter any Injury or other traumation. 2 Marned 1 Never Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1959-63 Specify: þ Bluck 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be chie Betters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) Avenue Bultimore MD 21216 Maxine Arunal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bay view Cremitory March 29,06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundry Service Consecution 22. Name and Address of Facility Belain Road, Saltimore MOZ1206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) Architicma **Physician** Gra /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of). Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes ospitel or Attending Physicien: hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? s after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours af To the Funerel DI 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar 560

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ewers

32. Registrar's Signature

och

MAR 2 9 2006

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician March 22,2006 11:00a Lockwood Brineman Elena /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Sacred Heart Home Hyattsville Prince George's if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/27/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** Months Days Hours 1 ☐ M 2 ☑ F 87 572-03-5301 Cuba Director Usuel Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. Stete 10b County Itam 27 Is marked other than "naturel", or items 23e or 28s-f show other traumatic event, the Medical Examiner must be notified at Hyattsville MD Prince George' 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20782 5805 Queens Chapel Road USA Funeral 72 hours after death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Mentai and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked or any Injury or other traumatic ev Georgia Scott Frederick J.Lockwood 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Cod 20017 19a. Informant's Name/Relationship (Type, Print) 1309 Newton Street N.E. Washington, D.C. Anne Anderson/Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4/01/06 Hunt, Texas Hunt Japonica Cem. 5 ☐ Other (Specify 4 Donation 21. Signatur Juneral Service Livense 22 Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart failure Examiner Due to (or as a consequence of Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 □ No 3 ☐ Probably 4 ☐ Unknown ۾ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 2 No 210 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To this 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No after death. Director: Af 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a Certifier ş 29d, Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Road, Ellicott City, MD 62 ) alazar 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State 2006 Registrar

DHMH 16 Rev 6/95

			For Stata Ragistrar	State of Ma	aryland /		tment of H			iene	6 09535	
			Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	3. Time of Death	-
	Physici /Medic		James Richar	d Barrett	Sr.				March	21, 20	<sup>Year</sup> 006 7:45P <sup>M</sup>	
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death		4c. County		
	N/		Baltimore Was	hington Mo	ed Ctr	:	Glen B			Anne	Arunde1	_
	Funeral			.Sex 7.Age	e (In yrs. last b	rthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)	t
	Director		213-28-5816 Usual Residence of Decedent		75	TIS.			12/11/1	.930	PA	_
	land ow		10a. State 10b. County		10c. City, To	wn or Loca	ation				10d. Inside City Limits	
	Mary III	ţo	MD Anne	Arundel	Pasad	lena					1 ☐ Yes 2 ☑ No	
	death with the Maryland ms 23a or 28a-f ehow rmet be notified at	Director	10e. Street and Number				10f. Zip Code		11	Og. Citizen of W	/hat Country?	_
	23a c		441 Maryland	Avenue			21122			U.S.	Α.	
	r dea	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?			as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Dican, etc.)		- American Indian, k, White, etc.	
9	s within 72 hours after death with the Marylan liene. rthan "natural", or Items 23a or 28a-f ehow the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	<sub>∞</sub> 1952- 1953	1 [	☐Yes 2 <b>X</b> No	Specify:		Specify:		
5-0036	tural E.E.	pa p	15. Decedent's	Year or Dates:		a Decede	int's Usual Occupa	ation		16h Kind of Bu	White siness/Industry	_
ÿ	n "nai	Completed	(Specify only highest	grade completed)		(Give k	ind of work done of NOT use retired	furing most of won	king	TOD. Taile of De	on lood in doorly	
7 7	s within piene.	E	Elementary/Secondary (0-12)	College (1-4or 5	,	ruc	k Drive	r		Truck	ing	
פ	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle, La	ist)				18. Mother's Nam	ne (First, Middle, M	faiden Sumame	θ)	
/lan	D & 2 0	70	Roy Barrett					Julia	Massey	7		
a	and and is mu		19a. Informant's Name/Relationship						ral Route Number,			
e) S	s 1 and 2 should Health and Milem 27 is mari		Teresa Barret	t / Wife	_	-		d Avenu			MD 21122 City or Town, State	
E E	00-		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3		cemet	ery, crema	tion (Name of atory or other place	1			, , , , , , , , , , , , , , , , , , , ,	
	rtmer rtent rtent		4 Donation 5 Other (Spe		Glen			Pk   03/2			urnie, MD	_
Baiti	permit. Pag Department Importent: i any injury o		21. Signature Francial Section	risee		300000	Name and Addres	О.	J.Gonce e, Pasa		ral Home, PA MD 21122	1
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Ca	rdian	. 0	rrhu	thmia			Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence		Q	( -	0- 1	•	minister	_
	Examiner		Sequentially list conditions,	b. Acu	Je r		ocandi	a 1 12	tand)	JON	1	
/	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	l arms	a consequence		thero.	10 10 00	4	100 - 10	Severa	
/_	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	C	~a r a conseque de		77670	o ero,	176	ال و دريدو	- geno	
2/PU	cate be ex physicien the buria	dical E			liab	e te	1 me	lli tu.	5		10 year	<b>y</b>
S		edic		v.							0	
X Q	death certiff e attending id for use as	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		th 3∏E	ctopic pregnancy				e of delivery	
		sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at 9 Unknown			Other (specify)			Mon	nth Day Year	
7	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/Me	9 Unknown  Part II. Other significant condition		ut not reculting	in the une	fortying cause gave	on in Part I	23a Did tob	acco use contr	ribute to the cause of death?	_
g D	signe d be	d by	prosta	te car	-10 V -	tr	ented	with			3 Probably 4 Dunknown	
ecord	requ been shoul	etec	1700,,,	ha)	in the	D. 1	1	(0.04)	-			_
ĕ	ela has je 2	Completed	1 14	1.45	-) OT 17 V	7 -	1 years	7480	24a. Was ai autops perform	ned? p	Vere autopsy findings available trior to completion of cause of leath?	
VITAI	ician: Th certificete rector, pag	မ C	25. Was case referred medical	W210V	× 47	)ean	<u> </u>	OC Plans of Das			Yes 2 No	
	ysician: is certific director,	0 0	examiner?	Hospital:	int 2 ERVC	Outnatient	3□ DOA Othe		th <i>(Check only on</i> ome 5□Reside		ar (Specify)	_
o	Attending Physician: or death. ector: After this certific by the funeral director,	Ë	27. Manny of Death	28a. Date of Inju	ry 28b.	. Time of Injury	28c. Injury Work	at	28d. Describe ho			_
0	endin sath. or: Af he fur	atic	1 Matural 5 Pending investiga	tion	, , , ,	підагу		Yes 2□No				
DIVISION	7 2 2 2	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury · At home, c. (Specify)	farm, stree	et, factory, office		28f. Location (St. City or Town	reet and Numbe , State)	er or Rural Route Number,	
_	spital hours a merel		29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	ge, death	occurred at the tim	ne, date and place	, and due to the ca	iuse(s) and mar	nner as stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Expone)  29b. Signature and title of certifies.	caminer: On the basis of and manner sta	examination a	and/or inve	29c. License				and due to the cause(s)	_
,	2 × 5 8		Chru - Certifie	- Sharle	k.M.S	*	1	1	1			
	1 x1		30. Name and address of person with	no completed cause of d	eath (Item 23a	) (Typa. P	rint)	, , , , ,			N )	
	Q'		Jerry D-SK	ARBEK, M.D	CUL	18	Bultim	ure -Az	7/0 Bun	s Blv	22,2006 d. Pasadena, n. 9211221	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	he 4	Cost 8					
	Registr	ar	MAAD 9	0 2006	BARTH FU	5° . 18	200					

				1 - State Registrar	State of Ma	-	artment of	f Health and N of Death		giene 06	09536
		8 9	40	Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
		Physici		LORETTA ELIZA	ветн ви	RNHAM			MARCH	23,2006	1:08 p <sup>M</sup>
	, C.	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town	n, or Location of Death		4c. County of I	
		LXumii		UPPER CHESAPEA	KE HEALT	Н	BEL	AIR		HARF	'ORD
		Funeral		Social Security Number     6. Sex		(In yrs. last birthday)	If Under 1 Ye		8. Date of Birth	year) 9.	Birthplace (State or Foreign Country)
	net.	Director		219-18-0337	M 20 F	80 Yrs.		, , , , , , , , , , , , , , , , , , , ,	APR. 2	20,1925	MARYLAND
		put *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
		eho eho	5								1 ☐ Yes 2 🛱 No
		the N	ect	MD. BALTIM  10e, Street and Number	ORE	BAL	TIMORE 10f. Zip Cod		1	10g. Citizen of Wha	**
٨.		with	٦	617 47th STREE	m			224		U.S.	•
Š		within 72 hours after death with the Maryland ene. than 'natural', or iteme 23e or 28e-1 ehow he Medical Examinat musi De notified at	by Funeral Director		12. Was Decedent Ev	ver in U.S. 13. 1			pecify Yes or No-		American Indian,
36	10	r Hen	FE	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No	)	f Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	Btack, \	White, etc.
71)	936	urs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2 <b>X</b> ∏1	No Specify:		Specify: W	HITE
	21215-0036	2 ho	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Oc	cupation	kina	16b. Kind of Busin	ess/Industry
	215	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use re	one during most of won tired)	ung		
		77 75 14 14	Son	12		Н	OUSEWI			DOMES	STIC
0	nd	o a d	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
70	<u>ya</u>		ို	HUGH MADSEN					AROLINI		
~	Maryland	and and our	1 6	19a. Informant's Name/Relationship (Type				eet and Number or Ru		•	
23		and feel	1 5	LINDA McMANUS/ D	AUGHTER	1317 20b. Place of Dispo			L., BELA	AIR, MARY 20c. Location - Cit	LAND 21015
3	0	Pages 1 nent of H int: if ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, crer	natory or other	place)			
1.7	Ë	Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)				CONAL 3/2	7/06 I	BALTIMOR	RE, MARYLAND
	Baltimore,	permit. Pages 1 Depertment of H Important: If its eny injury or ot		21. Signature of Funeral Service License		L L	I. Name and Ad	dress of Facility  ZEILER	INC. FU	JNERAL H	IOME
		un = o u		23a. Part1. Enter the disease, or compli		7	00 S.	CONKLING	STREET	r,BALTO.	MD. 21224 Approximate
				shock, or heart faiture. List only or	e cause on each line	ne death. Do not ent	er the mode of	dying, such as cardiac	or respiratory an	1851,	tnterval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition resulting in death)	whoe		in to	erchion			
		/Medical Examiner			Due to (or as a	consequence of):					
$\cap$			-	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to for as a	consumence of					
36	V	nsit	Examiner	Cause (Disease or injury							
7	,	be executed sicien and burial-transit	Xa	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
33/1480	8760	Physicien: The law requires thet the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burat-transit	dlcal		. =						
2	9	tificate ig phys as the	ed								1
Z	ŏ	eath certific ettending p for use as	Physician/Me	230. Was decedent prognant	3c. tf yes, outcome o		Ectopic pregna	2004		23d. Date o	
S	a.	deat	icia	in the past 12 months?	4 Pregnant at ti		Other (specify			Month	Day Year
Ш	Ö.	thet the d ad by the detached	, L	9 □ Unknown	9LI ONKHOWN				-		
.)	s,	es the igned be de		Part II. Other significant conditions cor						_	ite to the cause of death?
72	ord	v requir been si should	ted	mpo reside	Ischem	ic Ha	ich D	انحويد	1 🗆 Y	es 2021No 3[	☐ Probably 4 ☐ Unknown
Loretta	Record	law r as be 2 sh	Completed by						24a. Was autop	sv prio	re autopsy findings available ir to completion of cause of
5	H	The ate h page	P P						perfor	med? dea	th? Yes 2 No
7	Vital	icien: The certificate harector, page	Be	25. Was case referred to medical examiner?				26. Place of Dea	th  Check only or	ne)	
(	of V	hysic his ce I dire	ု	1 ☐ Yes 25 No	lospital: 1 🗌 Inpatien	t 2 FVOutpatier	t 3 DOA	Other: 4 Nursing H	ome 5 Resid	lence 6 Other	Specify)
$\Xi$		ding Ph h. After th funeral		27. Manner of Death 1 ► Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		njury at Work?	28d. Describe h	ow injury occurred	
2	Sio		cati	2 Accident investigation 3 Suicide 6 Could not be				1 Yes 2 No			
2	Division	or Atten efter deat Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str <i>(Specify)</i>	eet, factory, offi	ice	281. Location (S City or Tow		or Rural Route Number,
Burnham		To the Hospitel or A within 24 hours effer To the Funeral Direction places of the Completely filled in by		29s Conflict Certifying Phys	iniam. To the bear of	Win beginning as the sail	Company of the con-	e time, date and place	and short to the	and the same of the same	or ne stabut
(2)		Hos Pun Fun	dicai			examination and/or in		ny opinion, death occu			
-		ithin i	Med	29b. Signature and title of certifier	and manner state		29c. Lic	ense number		29d. Date signed (A	Month, Day, Year)
		⊢ ≱ ⊢ ö		S. Page	eraje.	$m_{\mathcal{D}}$	0	- (Des)			
		[	4	30. Name and address of person who co		ath (Item 23a) (Tuno					xcoc)+
		ク		S. Caguro	· · · · · · · · · · · · · · · · · · ·		-	od poo	ad Be	loir.	up Tront
		Sta		31. Date filed (Month, Day, Year)	32 Registra			······································			
	150	Registr	TOP	865D 0 4 20	DC E	17 Red					

		•	For State Registrar		State o	f Marylar		artmen <i>rtificat</i>				lental Hy	giene Reg. No.	06	1953	7
1	Dhuaiai		Decedent's Name	(First, Middle, Las	t)	-	0 -	1				2. Date of De	ath	Year Year	3. Time of	Death
	Physici /Medic		Berno	adette			Bro	hai	wn	)		March	23, 2	2006	6:00	а м
	Examin	er.	4a. Fecility Name (If	_	street and nur	mber)				Location	of Death			County of Death		
			5. Social Security Nu		ax .	7. Age (In yrs.	last birthday	Lanso	10Wne	If Under	24 Hrs.	8. Date of Birt		timore 9 Bigbs	olece (State o	v Foreign
	Funeral Director		216-14-47		⊒M 2∏дF	81	Yrs.	Months		Hours	Min.	May 18	, Year 2	24 Mary	Tand	ir i oroigir
	p		Usual Residence of			10.0										
	anylau show	ā	10a, State MD	10b. County Baltimore	2		ty, Town or Lo sdowne	ocation						'	10d. Inside Ci	ty Limits 2 ☑ No
	the M	Director	10e. Street and Num					10f. Zir	Code				10a Citiza	en of What Cou		- 24
	with Ma or		2217 Smit					2122					U.S.A		iliy:	
	death me 2;	Funerai	11. Marital Status			edent Ever in U		Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No	- 14	4. Race - Americ		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	[ 호	1 ☐ Never Marrie		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 <u>%</u> }No		if Yes, spe 1 ☐ Yes		Specity:		Rican, etc.)	5	Black, White, Specify: whi		
5-0	72 ho	Completed	(Speci	15. Decedent's Ed fy only highest gra			16a. Dece	dent's Usu	al Occupa	ition u <i>rina</i> mos	t of worki	ina	16b. Kind	d of Business/In	dustry	
2	Aithin ne.	m jg	Elementary/Secon		College (	I-4or 5+)		kind of wo					D - 4	<b>.</b>		
22	e filed within al Hygiene. I other then '		17. Father's Name (i	First Middle Last)			Book	кеере	21	18 Mothe	ar's Name	(First, Middle,		t Store		
and	d be f antal I red of	o Be	Leslie Ba									Seger		oumame)		
ary.	2 should be and Mental Is marked o	မ	19a. Informant's Na		ype, Print)		19b. Maili	ng Address						Town, State, Zip	Code)	-
ž	1 and 2 Health a tem 27 ls		J. Charle	s N. Brol	nawn/Hu	sband	2217	Smith	a Ave	nue I	Lansd	lowne M	212	.27		
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.			osition Cremation 3   5  Other (Specify		State	Place of Disponentery, created and Particular Particula	matory or o	other place			-2006 ]		ation - City or To .more, M		
Balti	permit. Departm Importer any inju		21. Sunature of Fur			in the	1 2	2. Name ar	nd Addres	s of Facili	y Hom	ne of La	ansdo			
			23a. Part1. Enter th shock, or hear	e disease, or comp	olications that o	auted the dea								wiie PiD	Approximat Interval Bet	θ
П	Physician		Immediate Cause (I	Final	1				11.	150					Onset and	Death
	/Medical		resulting in death)	-	a. Due to	Or as a consec	quence of):	1	<u>u</u> i i i	71 0	Λ .				rau	4
	Examiner		Sequentially list con	ditions.	b. Ch	ronic		ostro	uch	ve -	Pulr	nman	y Dis	ease	( ye	ers
V	be sit	inei	Sequentially list con if any, leading to imi cause. Enter Under Cause (Disease or i	mediate lying	Due to	or as a consec	quence of):									
4	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) L		c	or as a consec	uence of):						)			
8760,	s be e	dical E			4									:		
687	ificate g phy: as the	edic			0											
P.O. Box	that the death certificate be executed od by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ₹ 9 □ Unknown	nonths?	1 Live b	come of pregn rirth 2 □ Feta rant at time of c own	aldeath 3	⊒Ectopic p ⊒ Other (sp					23	3d. Date of delive Month	-	<b>Yea</b> r
	res that igned b be deta	by Pt	Part II. Other signifi	cant conditions co	ontributing to d	eath but not res	sulting in the u	nderlying o	ause give	n in Part I		23e. Did to	obacco us	e contribute to	he cause of c	leath?
rds	v require been sig should b	ed b										10	∕es 2□	No 3 Prot	oably 4 □l	Jnknown
Vital Records,	e lav has ge 2	Completed												24b. Were auto prior to co death? 1 \( \subseteq \text{Yes}	mpletion of c	available ause of
ita	10 -	BeC	25. Was case referr	ed to medical						26. Place	of Death	Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	S S =	ToE	examiner? 1 ☐ Yes 2 ☑	Vo			ER/Outpatier	nt 3 🗆 🗅 🗅	OA Cthe	4 D Nu	rsing Hor	me 5 Aresid	dence 6	□Other (Specif	(y)	
Division of	ding P. After fune		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 2	28c. Injury Work 1 🔲 Y	at ? ′es 2 □		28d. Describe I	now injury	occurred		
Divis	tel or Attenders after deatles Director:	Certification;	3  Suicide 4 Homicide	6 Could not be determined	289. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, st	reet, factor	y, office			28f. Location (3 City or Tov	Street and vn, State)	Number or Rura	al Route Num	ber,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier (Check only one)	1  Certifying Ph 2  Medical Exam	iner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as s place, and due to	tated. o the cause(s	:)
į.	To the ly within 2.	Me	29b. Signature and	title of certifier	1,0			290	c. License	number	~ ~			signed (Month,		
•			1/4	-110	7			1	too	243	33/		March	1 23,2	.006	
	X		30. Name and address Richard	G. St	efana	COID	0 3	250	Sto	ertin	ig Gi	ute ct	we	h 23,2	EME	37
	Sta Registr		31. Date filed (Monti	h, Day, Year) AR 2 9 20	78.7	egistrar's Signa	ature	este s			,					
DH	MH 17 Rev 1/2	001			mark.		· ·									

	ian		n Name (First, Middle, L d Charles	•	Ce	ertificate of	Death	2. Date of De Month	Day	Vear Year	3. Time of Death		
/Medi	cal					45 Ch. T-			26, 2				
Exami	ner		me (If not institution, gi			4b. City, Town,	or Location of Deat Notting			nty of Death			
Funeral Director		5. Social Secu 215-2	28-4597 6.	Sex 7. Ag	e (In yrs. last birthda 74 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bir	1		place (State or Fore ntry)		
A 11		Usual Resider	nce of Decedent 10b. County		10c. City, Town or	Location					10d. Inside City Lim		
ame 23a or 28a-f show	tor	MD	Baltin	nore	Notting	ham					1 □ Yes 2 🛂 N		
or 28	Director	10e. Street an				10f. Zip Code			10g. Citizen o		•		
238	rai		rhall Cour			21236				d Sta			
2 4	by Funeral		atus Married 2⊡ Married wed 4 ⊠Divorced	12. Was Decedent Armed Forces?  1-12 Yes 2 1 1 1 Yes, Give Year or Dates:	1952-1954	. Was Decedent of it. If Yes, specify Cub. 1 ☐ Yes 2 No.		Specify Yes or No to Rican, etc.)	Spec	ace - Ameri lack, White, cify: Whi	etc.		
6 0	ted		15. Decedent's 8	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of				
at Hygiene. I other then "n vent, the Wad	Completed	Elementary	(Specify only highest gi /Secondary (0-12) .2	College (1-4or 5	)+)	e kind of work done DO NOT use retire ctrician	during most of wo	rking	Paper	:			
if Health and Mental Hygiene. Itam 27 is marked other then "n other traumatic event, the Mad	To Be (		ame (First, Middle, Las rd Boulden	t)				me (First, Middle, linewacht		ame)			
27 is my r traum			nt's Name/Relationship Carolyn J. So			ling Address (Street Perhall (			-		Code)		
Department of Heelth a important: If itam 27 is any injury or other training once.			of Disposition		ce)	Date Mar 29 20c. Location - City or Town, State Beltsville, Maryland							
Depertrum imports any inju		21. Signature	of Funeral Service Lice	lu i	M10984	Name and Addre Cremation 8717 Gree	ess of Facility and Fune: n Pasture:	ral Alter s Drive	natives Baltimo	re, Ma	ryland		
hysician /Medical		23a. Part1. E shock, o Immediate Ca disease or co resulting in de	endition	a		nter the mode of dyi	-		rrest,	Beltsville, Marylandatives			
xaminer				_									
sicien and e burial-transit	cal Examiner	Sequentially I if any, leading cause. Enter Cause (Disea that initiated a resulting in de	ist conditions, to immediate Underlying se or injury wents eath) Last	c	a consequence of):								
nding physicien and use as the burial-transit	Cal	IF FEMALE: 23b. Was dec	eedent pregnant	c.  Due to (or as  d.  23c. If yes, outcome	a consequence of):  of pregnancy 2   Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y	202		Date of deliver	ery Day Year		
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fler this certificate has been signed by the ettending physicien and ineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1   Yes 25. Was case examiner? 1   Yes 27. Manner of 1   Action	referred to medical  Poath  The property of th	c. Due to (or as  d.  23c. If yes, outcome 1	of pregnancy 2 Festal death 3 time of death 5 ut not resulting in the	Other (specify) underlying cause gro  ont 3 □ DOA Other  of 28c. Injun  Mo 1 □	ven in Part I.  26. Place of De:  1er: 4 □ Nursing H	24a. Was autop performent of the check only come 5 2 Resident 28d. Describe for the check only come 5 2 Resident of the check only come 5 2 Resident of the check only come 5 2 Resident of the check only compared to the check only compare	obacco use co	Anoth  3 Prot  D. Were autoprior to co death? 1 Pes	Day Year the cause of death? pably 4 □Unkno ppsy findings availa mpletion of cause of 2 □ No		
fler this certificate has been signed by the ettending physicien and ineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was ded in the part II. Other s 25. Was case examiner? 1   Yes 27. Manner of	pedent pregnant ist 12 months? 2   No nown   significant conditions   referred to medical   2   No   Death   al   5   Pending ent   investigation   determined	C. Due to (or as  d.  23c. If yes, outcome 1	of pregnancy 2 Fetal death 3 time of death 5  ut not resulting in the  nt 2 ER/Outpatie y Year) 28b. Time Injury  ury - At home, farm, s c. (Specify)	Other (specify) underlying cause gro ent 3 DOA Other of 28c. Injury Wo M 1 treet, factory, office	yen in Part I.  26. Place of Dei ner: 4 □ Nursing H ry at rk? Yes 2 □ No	24a. Was autor period 1 Yes ath Check only come 5 2 Resid 28d. Describe to City or Toy	obacco use co	Alonth  antribute to the second of the secon	Day Year  the cause of death?  pably 4 Unknow  posy findings availa  mpletion of cause of  2 No  y)		
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State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2006

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate			-	giene Reg. No.	16	0953	39
	Physici		1. Decedent's Name (First, Middle, Last						2. Date of De Month	Day	Year	3. Time of	Death  M
>	/Medio Examin		Henrietta Brun  4a. Facility Name (If not institution, give		TAL.	4b. City, To	wn, or Lo	ocation of D	MARCH Death		nty of Death	NIA	/
	Funeral Director		5. Social Security Number 6. Se.	x 7. Age ☐ M 2∏ F	86 Yrs.	If Under 1 Months		f Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da June 2	th ly, Year) 6, 1919	Cou	place (State ontry) Tyland	r Foreign
	Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Town or L							10d. Inside Ci	•
	with the 3a or 28a-	I Director	10e. Street and Number 6116 Belair Road		Daicin	10f. Zip C	ode 212	206		10g. Citizen o			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f ehow any rightry or other traumatic event. I'm Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 20 N If Yes, Give Year or Dates:		Was Deceder		anic Origin Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		Race - Americ Black, White, cify: bla	etc.	
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) unk un	e completed) College (1-4or 5	(Give	dent's Usual kind of work DO NOT use	done duri	on ing most of	working unk	16b. Kind of	Business/In	dustry	unk
Maryland 2	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last)			uı	1k 18	3. Mother's	Name (First, Middle,	Maiden Sum	ame)		unk
	and 2 sho Balth and N n 27 is ma		19a. Informant's Name/Relationship (Ty Alana Williams/Dep		g			i Number o	r Rural Route Numbe	er, City or Tox	vn, State, Zip	Code)	unk
Baltimore,	i. Pages 1 tment of He tant: If Iter ijury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 \(\frac{\text{X}}{2}\) Other (Specify)	in state	20b. Place of Disp cemetery, cre	matory or othe	r place)		Date	20c. Locatio			
Ba	permit Depar Impor any ir		21. Signatur Funeral Service Licens	Upel	B	altimon	e, M	D 21	ard 655 W. 201		more S		
la de	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ROBAL	the death. Do not en	£			Lu FARC			Approximate Interval Bett Onset and D	ween
8760,	cate be executed by yes clan and burial-transit and burial-transit burial-transit and bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):								
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1□Live birth 24□Pregnant at 9□ Unknown	2 ☐ Fetal death 3 [	⊒Ectopic preg ☑ Other (spec					Date of delive	,	'ear
S, D	quires that the signed by and be detacted.	by	Part II. Other significant conditions cor	ntributing to death bu	it not resulting in the u	nderlying cau	se given ii	n Part I.		obacco use co (es 2 \sum No			eath? Inknown
I Record		Completed							24a. Was autop perfor 1  Yes	sy	o. Were auto prior to cor death?	psy findings ampletion of ca	ivailable luse of
Vita	yaiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:	./		-	3. Place of I	Death (Check only o	ne)			
Division of	<u> </u>	tlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	28b. Time o		Injury at Work?	4 ☐ Nursin	g Home 5 Resid			y)	
DIVIS	al or Attending Possible as after death. I Director: After the in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, st . (Specify)	eet, factory, o	fice		28f. Location (S City or Ton		nber or Rura	l Route Numb	er,
	To the Hoapital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best of ner: On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	n occurred at a vestigation, in	he time, o my opinio	date and pl	ace, and due to the occurred at the time, o	cause(s) and r date and place	manner as st e, and due to	ated. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	(2	- 1		cense nu			29d. Date sign			
			30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type.	Print)	170	COX	8 / HAVER MARS	1 1300	117 ×	200	76
			STEPHEN G. H	EXTECLAL	UMD	13	ALTI	make	MAR	MAND	21	239	?
	Star Registra		31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registra	s Signature				,				

			1 - For State Ragistrar		aryland / Dep	artment of Health and rtificate of Death	Mental Hygi	_	09540
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last     Aa. Facility Name (If not institution, give     Mariner Health Ca	Eleanor		Bowman  4b. City, Town, or Location of Dea  Bethesda	2. Date of Death Month March 2	Day Year	12:34 PM
	Funeral Director		Social Security Number 6. S.		e (In yrs. last birthday) 81 Yrs.			9 B	irthplace (State or Foreign Country) China
	the Maryland 28a-1 ehow	ector	10a. State 10b. County Maryland Montgome  10e. Street and Number	ery	10c. City, Town or Lo	Bethesda			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	th with 23a or	ai Dir	5206 Wilson Lane			10f. Zip Code 20814	10	og. Citizen of What C United St	•
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, If a Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: W	
Maryland 21215-0036	d within 72 h giene. er than "natu i tra Medical	completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) SICIAN	rking	6b. Kind of Busines:	ŕ
ryland	should be filed nd Mental Hygis marked other imatic event, in	To Be C	17. Father's Name (First, Middle, Last) Smith Hempstone 19a. Informant's Name/Relationship (7)	ivoa Priati	10h Maili	E1i	me (First, Middle, M zabeth No	yes	
	s 1 and 2 should if Health and Mer item 27 le marke other traumatic		Ellen Bowman Perm		er 5206	ng Address <i>(Street and Number or Al</i> Wilson Lane, Bet			
Baltimore,	permit. Pages 1 Department of He Important: If iten any Injury or oth		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	500	Cremator	sition (Name of natory or other place) ium, Inc. 20 Name and Address of Facility bert A. Pumphrey 57 Wisconsin Ave.,	ch 29, 06	Oc. Location - City of Bethesda,	Maryland
	Icate be executed physicien and physicien and physicien and physicien and suppression in the property of the physician in the	dicai Examiner	23a. Part1. Enterthe disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsi Due to (or as Urina b. Due to (or as Cellu	I the death. Do not ent ne.  S a consequence of): ry Tract In a consequence of):	er the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death 2 weeks  2 weeks  4 weeks
. Box	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
ords, P	The law requires that the ate has been signed by the page 2 should be deteched.	Ď	Part II. Other significant conditions co Diabetes Mellitu	ntributing to death bi	ut not resulting in the ur ension	derlying cause given in Part I.			o the cause of death?
	The lay ate has page 2	e Completed	25. Was case relerred to medical				24a. Was an autopsy performe 1 🗆 Yes 2	prior to death? No 1 □ Yes	utopsy findings available completion of cause of 2 No
<u> </u>	ysicle iis cert direct	ToB	examiner?	Hospital:	nt 2 ER/Outpatien	0.1	th (Check only one) ome 5□ Besiden	ce 6 □Other (Spe	acity)
Division of	To the Hospital or Attending Physician: In the Fours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28d. Describe how	r injury occurred				
٥	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc		eet, factory, office occurred at the time, date and place	City or Town,		
	To the Hospi within 24 hou To the Funer completely fill	ledical	one)	ner: On the basis of and manner sta	examination and/or inv	estigation, in my opinion, death occu	, and due to the cau rred at the time, dat	e and place, and due	s stated. e to the cause(s)
	Z viti	≥	29b. Signature and title of certifier			29c. License number D0053615		d. Date signed (Mont March 28,	
	15	+	30. Name and address of person who co			Print) e Pike, Rockville			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registra	r's Signature	e like, KUCKVIII	z, maryiai	11a 20852	

_			For State Registrar	State of M	aryland / (	•	artment o			nd Me		giene	16	09541			
	Physici	an	1. Decedent's Name (First, Middle, Last	)							2. Date of Dea	ath Day	Year	3. Time of Death			
	/Medic	cal	SHAWNISHA BIGGU								March	23, 200		1:07 A M			
	Examin	er	4a. Facility Name (If not institution, give Johns Hopkins Hos				4b. City, Tov Balti			t Death		4c. County					
	Funeral		Social Security Number 6. Se.	x 7. Ag	e (In yrs. last bil	thday)	If Under 1 Y	ear	f Under 2		B. Date of Birt	h		place (State or Foreign			
	Director		217 <b>–</b> 25–7430	]M 2∭∑]F	17	Yrs.	Months Da	ays	Hours	Min.	(Month, Day 8-25-	-1988	MAR	YLAND			
	and w _		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation							10d. Inside City Limits			
	Maryl.	ō	MD. N/A		BALT									1 XYes 2 No			
	r 28a	rec	10e. Street and Number		<u> </u>		10f. Zip Co	de				10g. Citizen of V	Vhat Cou	ntry?			
	th with	Funeral Director	806 BRADHURST R	D.			212	12				USA					
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent f Yes, specify	of Hisp Cuban,	anic Orig Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	14. Raci	e - Americk, White,	can Indian, etc.			
36	rs afte	by F	Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		1□Yes XO	No s	Specify:			Specify: BLACK					
2-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow fa Marical Examinar must be motilled at	ted	15. Decedent's Edu	cation	16a	. Deced	dent's Usual O	ccupatio	on			16b. Kind of Business/Industry					
2121	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or:	5+)	life. l	kind of work d DO NOT use re	one duri etired)	ing most	of working	9						
N	filed wi Hygien other th	Co	-9-	<b>-</b> 0-			STUDENT		0. Marka	de Norse	(Fine Addition)	14: id=a G:	- >				
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last)  FLOYD BIGGUS					18		AN CA		Maiden Sumam	Maiden Sumame)				
Ž	2 should be and Mental Is marked o	2	19a. Informant's Name/Relationship (T)	rpe, Print)	196	. Mailin	g Address (St	reet and				er, City or Town,	State, Zij	Code)			
	2 2 2		JOAN BIGGUS (MOT	HER)		806	5 BRADE	TURS'	T RD	• BAI	TIMORE	, MARYL	AND	21212			
JOAN BIGGUS (MOTHER)  806 BRADHURST RD. BALTIMORE, MARYLAND 21212  20a. Method of Disposition 1 Burial 2 (Cremation 3 Removal from State 4 Donation 5 Other (Specify)  METRO CREMATORY 4-1-2006  BALTIMORE, MARYLAND 21. Signature of turn fal Service Licensee JONATHAN D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.  1721-27 N. MONROE ST. BALTIMORE, MARYLAND											own, State						
Ē	t. Pages rtment of rtant: If It		4 □Donation 5 □ 9 (her (Specify)		METRO					<b>-1-</b> 20			ALTIMORE, MARYLAND				
Ba	Depermine Deperm		21. Signature of Furrial Service Licens	ONATHAN	D. HIB.	4								P.A. LAND 21217			
			23a. Part1. Inter the disease, or compl	ications that caused	the death. Do								1211(1	Approximate			
	Physician		shock for heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each II	Lole	Sh	net	Force	_	In	Line			Interval Between Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	Y				1000	3					
	Ladrinici	75	Sequentially list conditions, if any, leading to immediate	Due to for as	a consequence	oĎ:											
/	uted d ansit	Examiner	Cause (Disease or injury			o.,.											
,092	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):											
876	cate by	dlcal				_		_					-				
× 6	ding p	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy							22d Day	e of deliv	004			
Box	res that the death certifica igned by the attending pt be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		Ectopic pregn Other (specif					Moi		Day Year			
0	at the by the	hys	9 Inknown	9□ Unknown							T						
Division of Vital Records, I	The law requires that the death certificate be executed tie hes been signed by the attending physician and cage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions co	ntributing to death b	out not resulting i	n the ur	nderlying caus	e given	in Part I.		23e. Did to	~		he cause of death? pably 4 Dunknown			
eco	e law re hes bee	Completed									24a. Was autop	SV C	Vere auto	ppsy findings available impletion of cause of			
ā	ysician: The is certificate he director, page										12 Yes	rméd? d 2□ No 1	es	2□ No			
5	s certi	To Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	lospital: 1 ☐ Inpatie	ant 2 TVT=P/O	itnation	t 3□ DOA	Other:			Check only o	<i>ne)</i> Ience 6 ⊡Oth	er /Speci	60			
סר	Attending Physician: r death. ector: After this certifics by the funeral director.		27. Manner of Death	28a. Date of Inju (Month, Da	rv 28b.	Time of	28c	Injury at Work?				now injury occurr		,			
Sio	endin sath. or: Afi he fur	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	Faind /2	10	njury			s 2)	10 5	ubjec	Jsph.	da	rd cut			
Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 Homicide determined	28e. Place of In building, et	ury - At home, fac. (Specify)	arm, str	eet, factory, of	fice		28	City or Tow	vn, S <b>l</b> ate)		al Route Number,			
	spital ours a neral i		29a. Certifier 1 Certifying Phy	sician: To the hest	of my knowledge	death	occurred at the	ne time	date and	Inlace at		shum		<u>C</u>			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exami	ner: On the basis o and manner st	f examination ar	d/or inv	estigation, in	my opini	ion, deat	h occurred	at the time,	date and place,	and due to	o the cause(s)			
	To the Comp	ž	29b. Signature and title of certifier	0 0			29c. Li	cense n	umber			29d. Date signed	(Month,	Day, Year)			
}	0		1 and lor	Leurs	)			OCME	<u> </u>			March 23	3, 20	006			
	,7	(	J. Whon wik	empleted cause of		(Туре,		Penr	ı Str	ceet	Balti	more, Ma	iryla	and 21201			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2006	22. Registr	ar's Signature	234	E)										

DHMH 17 Rev 1/2001

ORIGINAL

Center

10c. City, Town or Location

Certificate of Death

	Marylan fedat	tor	10a. State 10b. County	1/4	10c. City, To	Wn or Location	りビ		
	with the M Sa or 28e-f I be notifie	Direc	10e. Street and Number	CTEOF	E/D		p Code 2/2/3		10
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Madical Examinar must be notified at any injury or other treumatic event, the Madical Examinar must be notified at any longe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 XN If Yes, Give Year or Dates:		13. Was Dece If Yes, spi	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specif erto Ric	y Yes or No- can, etc.)
215-0	hin 72 hours 8. 8n "naturel", Madical Exp	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed)  College (1-4or 5-		a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of w	rorking	
d 21	filed within Hygiene. Ither than	Con	17. Father's Name (Eisst, Middle, Last)			HOME	MAKER 18. Mother's N	ame (f	First, Middle, M
ylan	should be filed of Mental Hygi marked other imatic event, I	To Be	FRANK	KOBUS	5		VERE	Ni	CA U
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 sh Department of Heelth and Important: If item 27 is m any injury or other treum ang.		19a. Informant's Name/Relationship (  MAA TAM)  20a. Method of Disposition	BERING	20b. Place	Ob. Mailing Address  OPKV  ot Disposition (Natery, crematory or	(Street and Number or in the street and Number of Street a	Date	BALT
timo	permit. Page Department o Important: If any injury or once.		1 Serial 2 Cremation 3 4 Donation 5 Other (Specification)	(y)	57.	STANIS	SLAUS H	3	006
Ba	permi Depa Impo any is		21. Signature of Filneral Service Licer	Skard	eh.	22. Name a	RDA FH	2	BAY
			23a. Part1. Enter the disease, or com shock, or heart tailure. List only Immediate Cause (Final					ac or r	espiratory arre
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a GASTRO	consequenc	e ot):	BLEEDING		
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			hai' laan laan laan Ar/ ah 1 4 km2		-
/	secuted end I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. METAST			INTESTINAL	. CA	NCER
8760,	cate be ex ohysicien the buria	dicai E	ι	d					
ital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 0	2 ☐ Fetal dea	th 3 ☐Ectopic <sub>j</sub> 5 ☐ Other (s			
S, D	ss that I gned by se deta	by Ph	Part II. Other significant conditions of		t not resulting	in the underlying	cause given in Part I.		23e. Did tob
ord	require	eted	CONGESTIVE HEAD					-	1 🗆 Ye
II Rec	The law ate has b page 2 s	Comple	STROKE HISTORY						24a. Was a autops perform
	ician: certific rector,	Be	25. Was case reterred to medical examiner?	Hospital:			26. Place of D		
Division of V	ding Phys h. After this funeral di	tion; To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	y 28b	Outpatient 3 0  Time of Injury  M	28c. Injury at Work?  1 Yes 2 No		5 Reside
Divisi	To the Hospitel or Attending Physici within 24 hours effer death. To the Funeral Director: After this cer completely filled in by the funeral direct	Certification;	3 Suicide 6 Could not b	e Ope Place of Inju	ry - At home, (Specify)	farm, street, facto		281	f. Location (St City or Town
	A Hospit. 24 hours a Funera etely fille	edical C			examination :		d at the time, date and pla n, in my opinion, death oc		
<b>.</b>	To th. Within To the	Me	29b. Signature and title of certifier			29	9c. License number		2

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death 3. Time of Death MARCH Day 2006 9:36 AM

7. Age (In yrs. last birthday) | If Under 1 Year | It Under 24 Hrs. | 8. Date of Birth | Nonth, Days | Hours | Min. | Month, Days | Year | 92 Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 □ No

10g. Citizen of What Country?

USA

14. Race - American Indian, Black, White, etc.

16b. Kind of Business/Industry

Maiden Sumame)

DAN COLD

City or Town, State, Zip Code) D-, MD. 21093

Approximate Interval Between Onset and Death

>6MONTHS

5 DAYS

23d. Date of delivery Month Year Day

pacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No iy ned? 2X No

ence 6 Other (Specify) ow injury occurred

treet and Number or Rural Route Number, n, State)

ause(s) and manner as stated. ate and place, and due to the cause(s)

9d. Date signed (Month, Day, Year)

3/26/06 D 58944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTINE 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 BOUTZAL M. D. ,

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

1 - For State Registra

10a. State

5. Social Security Number

160-16-968

6. Sex

1 □ M 2 X F

**Physician** 

**Funeral** 

Director

/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 5 per fh 9854 4-11-06 vt. State of Maryland? Department of Health and Mental Hygiene State Registrar Amend Item #26 Per Phy C853 39719900 94 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2006 Mary Elizabeth Carroll 4:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3711 Gibbons Ave Baltimore N/A . Social Securit 0912 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 219-34-<del>8113</del> 69 Pennsylvania Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3711 Gibbons Avenue 21206 United States or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced "netural" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) 4 Years Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ie marked of Joseph Carroll Ethel Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Horwitz - Friend 48 Nicholas Alexander Drive, Port Deposit, MD 21904 item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H Important: If its eny injury or ot once. □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | Greenmount Centerery = Classification | Greenmount 03/29/2006 Hammonton, New Jersey 5305 Harford Road Leonard J. Ruck, Inc Baltimore, MD 21214 23a. Part1. Enter the disease or complications that caused the death, shock, or heart tailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot) Examiner the attending physicien end hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mort 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed 2□ No 1 Yes 2 . No After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 4 hours efter death. Funerel Director: A ely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral E completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature a 29d Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Registrar's Signature State 9 Registrar

			1 - State Registrar	of Maryla		artment of F			giene 006	09544
	Physici /Medio		Decedent's Name (First, Middle, Last)  J	oan C.	Carter			2. Date of Dea Month		
	Examir		4a. Facility Name (If not institution, give street and Sinai Hospital	(number)		4b. City, Town, o Balt	r Location of Deal	h	4c. County of De	eath
	Funeral Director		5. Social Security Number 212-36-4714 6. Sex	7. Age (In yr 68	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day		Birthplace (State or Foreign Country) Md
	e Maryland la-f ehow	ctor	Usual Residence of Decedent           10a. State         10b. County           Md         N/A	10c. (	City, Town or Lo	cation				10d. Inside City Limits 1 √ Yes 2 □ No
	h with th	al Director	10e. Street and Number 3917 Annellen Road			10f. Zip Code	1215		10g. Citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any fulury or other traumatic event, the Medical Examinational Emperiment and Appres.	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in d Forces? es 2 X No , Give or Dates:	1	Vas Decedent of H f Yes, specify Cuba □ Yes 2☑ No	lispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W Specify: B	
21215-0036	d within 72 ho giene. ir than "natur ibe Medical	Completed	15. Decedent's Education (Specify only highest grade completed processing the secondary (0-12)  12th grade	ed) ge (1-4or 5+) N/A	(Give	lent's Usual Occup kind of work done OO NOT use retired erk	ation during most of wo	rking	16b. Kind of Busines	•
Maryland	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last)  John Mason				18. Mother's Na Ola Ca		Maiden Sumame)	
	and 2 sho ealth and I n 27 ie ma		19a. Informant's Name/Relationship (Type, Print) Raymond Carter — Husb		3917	Annellen	and Number or Ri Road B	alto, Md	r, City or Town, State 21215	, Zip Code)
Baltimore,	Pages 1 Iment of H tant: If Itel lury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal fr  □ Donation 5 □ Other (Specify)	om State		sition (Name of natory or other place Forest V		-2006	Owings Mi	
Ba	permit Deper Impor any In		21. Sinarure of Juneral Service Licensee	chan			4300 Wa		nue Balto	o,Md 21215
8760,	Physician /Medical Examiners the pnual-transit the pnual-transit the pnual-transit pnu	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ROXISM to (or as a conse	PAL CA equence of): EAND A equence of):	RDIAC	DYSRHY	THMIA,		Approximate Interval Between Onset and Death 2-0-30 M/N,
.O. Box 6	death certifii e attending p id for use as	Physician/Med	in the past 12 months?	outcome of preg ve birth 2 Fe regnant at time of nknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions contributing to DIABETES MEL	o death but not re	esulting in the un	PERIPH	en in Part I. SLAL	23e. Did to	V	to the cause of death? Probably 4 □Unknown
$\mathbf{x}$	The ete h page	Completed	MARKED OBESI	ГΥ	ARTER	IAL DI	SEASE		med2 death' 2 XNo 1 ☐ Ye	autopsy findings available o completion of cause of es 2 \square No
Division of Vital	To the Hospital or Attending Physician: a within 24 hours abter death.  To the Funeral Director: After this certifices completely filled in by the funeral director, p	Certification; To Be	27. Manper of Death  1 Natural 5 Pending (A  2 Accident investigation  3 Suicide 6 Could not be determined	□ Inpatient 2  ate of Injury  Month, Day Year)  ace of Injury - At  iliding, etc. (Spec	28b. Time of Injury	28c. Injun Work M 1 🗀 '	er: 4 ☐ Nursing H	28d. Describe ho	ence 6 □Other (Spow injury occurred	
2	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by th	edical Cer	29a. Certifier (Check only)  2  Medical Examiner: On the	the best of my kr	nowledge death	occurred at the timestigation, in my op	ne, date and place pinion, death occu	and due to the c	auso(s) and manner	as stated. ue to the cause(s)
)	To the To the Comp.	Me	29b. Signature and title of certifier.	ending M. I	thysic	23c. License	1079	0	9d. Date signed (Moi	06
	10		30 Name an dress of person who completed of STEWART	M.D.	222 V	N. COLD	SPRING	LANE B	ALTIMORE	MD, 21210
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 2 0 2006	2. Registrar's Sign	A Angel	Les s				/

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Amend item 8 per fh 9854 4-4-06 vt
State of Maryland? Department of Health and Mental Hygiene

1 - For State Registrar Reg. No. UUS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** SUPRIYA CHOWDRY 2:59 PM March 26 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner University of Maryland Medical Center NIA Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Mond, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 50 1 ☐ M 2 🗶 F 218-90-2489 **Director** May 5, 1955 India Usuel Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Elkridge Maryland 1XXYes 2 ☐ No Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 8007 Greentree Court 21075 Itema 23a United State America death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian þ 3 X Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: if Item 27 ie marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) Medical Physician Assistant 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milan Mookerjee Leena Mookerjee 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al Important: If Item 27 ie eny injury or other trac 8007 Greentree Court Elkridge, Maryland 21075 Raj Baneejee/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Baltimore-Washington Crematory 29, 2006 Laurel, Maryland 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licenses 22. Name and Address of Facility Fleck Funeral Home VIII 7601 Sandy Spring Road Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Multiple Myeloma **Physician** one year /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dusto (cr as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ZNo autopsy performed 270 No 1 Yes 2 No the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident s after de... at Director: Ate 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Di Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Busannah Batury P 19657 March 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susannah Batko-yovino, M.D. 22 S. Greene St. Battimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2006 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician Betty Lee Calder 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hosedale If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day August 21 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Months 1930 Baltimore, Maryland 1□M 2□F Director 21.3 28 5454 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Maryland Baltimore County Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2917 Ontario Avenue USA or iteme 23s 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel; or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Baltimore Co. School Systems School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Charles R Wirth Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2... Department of Health as Important: If item 27 is eny injury or other trau 2503 Cider Mill Road Baltimore, Maryland 21234 Donald H Calder 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 27 2006 Baltimore Maryland Dulanev Valley Mem. Gdns. 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Signature of Funeral Sen ce Licensee ucho 7401 Belair Road Baltimore, Maryland 21236 enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Goquentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1∠2 Yes 2 □ No 1 X Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA this s after death. I Director: After this of in by the funeral di 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1) Natural Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a To the Funerel C completely ş

State Registrar

ca

29a. Certifier

one)

29b. Signature and title of certifier

MAR 2

30. Name an address of who completed cause of death (Item 23a) (Type, Print) reyer 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Franklin Square Drive Baltimore, MD Cornel

1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZLI Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

March

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		For		Sta	te of	Maryla	nd / Dep				nd Mer	ntal Hyg	jiene	Э		
		1 - State Registrar					Ce	rtifica	te of l	Death			eg. No	006	09547	
Physicia	e an	1. Decedent's Name Anna Mar		,								Date of Dea Month		y 2006 Year	3. Time of Death	
/Medic	al					to al		45 035	<b>T</b>	1		rch 22	-		7:50a <sup>™</sup>	_
Examin	er	4a. Facility Name (I		-	ula naim	Der)				Location of I	Death			County of Dea		
Funeral		5. Social Security N		6. Sex	7	'. Age (In yrs	s. last birthday	) If Unde	utus r 1 Year	If Under 24	4 Hrs. 8.	Date of Birth		altimore	45-1	
Director		213-14-9	371	1 □ M 2	StF	86	Yrs.	Months	Days	Hours	Min. Ma	rch 22	$\frac{Y_{\theta ar}}{1}$	920 Mary	yland	
p ,		Usual Residence of 10a. State	f Decedent 10b. County			100.5	City, Town or L									_
sho	2		,				•	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
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be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or iteme 23a or 28a-f show event, the Medical Exeminer must be notified at	Funeral Director	11. Marital Status		12. Wa	s Deced	lent Ever in	U.S. 13.	Was Dece	dent of Hi	ispanic Origin	in? (Specify	Yes or No-		14. Race - Am	erican Indian,	_
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ural'.	d by	3 🖾 Widowed	4 Divorced	Ye	ar or Dat	tes:		1 1 103	24.5 NO	Specify:				Specify:Whi		
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ld be ental ked c	To Be	William A	A. Froe	hlich						Mary (						
shou ind M i mar umat	-	19a. Informant's Na			nt)		19b. Mail	ing Addres					, City	or Town, State,	Zip Code)	-
and 2 salth a n 27 to		Joyce Oca	ampo/Ni	.ece			1323	Pop1	ar Av	enue A	Arbut	us MD	212	27		
of He of He of Hen or oth		20a. Method of Disp		3 □Remova	I from St		Place of Disp cemetery, cre	matory or	other plac	a)	Dafe			ocation - City or		
Pag tment tant: Jury o		4 Donation	5 Other (S	pecify)		We				i i				ton, MD		
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural', or i any injury or other treumatic event, I'm Medical Exemit once.		21. Signature of Fu	ineral Service	Ucensee	00			2. Name a	nd Addres se_Fu	ss of Facility neral	Home	, Inc.				
*	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												us MD 2	Approximate		
		shock, or hea Immediate Cause	irt fallure. List	only one caus	e on ea	ch line.							-	4	Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)		a	121	r as a conse	Sicen	311C	Car	010	vaso	cula	7 L	isoase	zoyears	_
Examiner					00 00 (0)	i as a conse	quence on.								•	
7.6	ner	Sequentially list confidence if any, leading to improve cause. Enter Under Cause (Disease or	nditions, nmediate eriving	D	ue to (or	r as a conse	equence of):									_
The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	>	c												
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eath certifi attending I for use as	Z W	IF FEMALE: 23b. Was decedent	t pregnant	23c. If y	es, outco	ome of pregr	nancy							23d. Date of de	fivery	
death e atte d for	cla	in the past 12 1 Yes 2	months?	4	Pregnar	th 2 Fet nt at time of		⊒Ectopic p ⊒ Other <i>(s</i> ;						Month	Day Year	
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res that igned to be det	by	Part II. Other signif	ficant condition	ms confributir	g fo dea	th but not re	suffing in the	underlying	cause give	n in Part I.		23e. Did tob	рассо (	use contribute t	o the cause of death?	
w require been si should b									-		_ [	1 □ Ye	s 2	□No 3□P	robably 4 Unknown	
e law has b	Completed											24a. Was a autops	V	24b. Were a prior to	utopsy findings available completion of cause of	
										4.40.44		perform 1 ☐ Yes 2	ned? No	death? 1 ☐ Yes	2 No	
sician: cartific rector,	Be	25. Was case reference examiner?		Hospital					Othe	· ·		heck only on				-
0 - 0	<u>د</u>	1 Yes 2 ☐ 27. Manner of Death			Date of	Injury	28b. Time of		28c. Injury Work		ing Home 28d	5 Reside		6 □Other (Spe ry occurred	ocify)	-
ath. r: Afte	atio	1 Natural 2 Accident	5 🗌 Pendin investig		(Month,	Day Year)	Injury	М		:? ∕es 2 □ No						
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could r determ		Pface of	f Injury - At I	home, farm, st	reet, factor	y, office		28f.	Location (St. City or Town	reet ar	nd Number or R	ural Route Number,	
ital o						(-,							, 51410	·'		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the tuner	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	Examinar: Or	the bas	is of examin	lowledge, dea lation and/or in	th occurred evestigation	at the tim	e, date and pointion, death	place, and occurred a	due to the ca	ause(s) ate and	) and manner as d place, and due	s stated. e to the cause(s)	
o the ithin 2 o the omple	Med	29b. Signature and	title of certifier		d manne	r stated.		29	c. License	number		25	9d. Da	te signed (Moni	th. Day. Year)	-
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10	1	30. Name and addre	ess of person	who complete	cause	of death (fte	em 23a) (Type	Print)		1441			·acri	0.1 22	2006	-
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	Physici	an	Decedent's Name (First, Middle, Las	st)						2. Date of Dea Month	Day	Year	3. Time of De				
	/Medic	al,	Hanes Chase				41. Oh. T.	. 1	- ( D + b	March	T	206	730A	• м			
	Examin	ier	4a. Facility Name (II not institution, give Genes is Itomews)	0 0			4b. City, Town, o		of Death		4c. County						
	Funeval		5. Social Security Number 6. S		Age (In yrs. la	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birtho	lace (State or F	Foreian			
	Funeral Director			□ M 2 <b>X</b> XF	98	V	Months Days	Hours	Min.	(Month, Day	Year) 4 1908	Cour	(y) RYLAND	or orgin			
	pu ,		Usual Residence of Decedent		10.00	-											
	aryla ahov	2	10a. State 10b. County		Toc. City	, Town or Lo						1	0d. Inside City 1 X Yes 2				
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303	72 hours after death with the Maryland hatural', or items 23a or 28a-f ahow dical Examiner must be notified at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		Yes 22XNo	Specify:			Specify	BLA	K 				
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12	within lene. r than "	ф	Elementary/Secondary (0-12)	College (1-4d	or 5+)		JSEWIFE	<i>a)</i>			N/A						
9	e filed other vent, L	a)	10th grade   17. Father's Name (First, Middle, Last)				SEMILE	18. Mothe	er's Name	(First, Middle, I		7e)		-			
lan	ould be Mental arked c	To B	unknown					Е	BETTY	BROOKS							
Maryland 21215-0036	2 should and Men ia marke aumatic	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura									City or Town,	State, Zip	Code)				
	1 and 2 Health tem 27 i		Charles Green/Ner	Wyanoke	Ave.,	Bal	timore,	Maryla	nd 2.	218							
ore	Pages 1 aunent of Heanint; If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		ace of Dispo: metery, cren	sition (Name of natory or other plac	ate	20c. Location -	City or To	wn, State						
Ē	Pag tment tant; jury		'4 ☐ Donation 5 ☐ Other (Specify	()	1		MORIAL PA						1ARYLANI	D			
Baltimore,	permit. Page Department of Important; if any injury or		21. Signature of Funeral Service Live	596/			Name and Addre LLIAM C 206 W NOR				FUNERAL	HOM	E P.A.				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Constructions of the cause of the control of the cause of th														
	Priysician	1	Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death  Onset and Death														
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Вох	eath certif attending for use a	ian/	23b. Was decedent pregnant in the past \2 pronths?		2 Fetal	death 3	Ectopic pregnancy	,			23d. Dai	e of delive	ry Day Yea	àr			
o.		ysic	1 ☐ Yes 2 <b>∑</b> No 9 ☐ Unknown	9□ Unknown	t at time of de	ain 5	Other (specify)										
<u>α</u>	that the		Part II. Other significant conditions of	ontributing to death	n but not resul	Iting in the un	derlying cause giv	en in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of deat	th?			
Vital Records,	w requires that the been signed by th should be detache	ed by								1 □ Y€	s 2 🗆 No	3 🗆 Prob	ably 4 Zunk	ınown			
000	law re as bee	Completed								24a. Was a		Vere autor	sy findings ava	ailable			
Ä	The lav	E								autops perform	ned?	leath?	npletion of caus 2DXNo	5 <del>0</del> O1			
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on			7.0				
of V	99 (0 =	မ	1 ☐ Yes 2 Ho	Hospital: 1 ☐ Inpa		ER/Outpatient		4 S NU		ne 5□Reside			)				
o uc	ling F	ion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury	28c. Injun Worl			28d. Describe ho	w injury occurr	ed					
Division	l or Attending Phy after death. Director: After thi in by the funeral c	icat	2 Accident investigation 3 Suicide 6 Could not be		Injury - At hor	no farm stre	M 1	Yes 2 □ I	- 1	28f. Location (St.	reet and Numb	er or Rura	Route Number	,			
<u>&gt;</u>	al or A s after i Dire d in by	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	)	ot, lactory, office			City or Town		51 51 71676	ricate rvarricer	•			
	To the Hospital or within 24 hours after To the Funeral Direction Completely filled in the Funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basis and manner	of examination	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, deal	d place, a	and due to the ca ed at the time, da	use(s) and ma ate and place, a	nner as stand due to	ated. the cause(s)				
	To the within 2. To the I complet	Me	29b. Signature and title of certifier				29c. License	e number		2	d. Date signed	i (Month, i	Day, Year)				
}			1 Political	)			DOE	0594	23	K	larch t	23 20	206				
	6		30. Name and address of person who	completed cause o	f death (Item	23a) (Type, I	Print)	10									
			Nchai Feinson	5601 Lac	strar's Signati	157 VD	1701 Bui	Iding #	303 ·	Bultma	R MD	2/23	7				
	Sta Registr		MAR 2 9 2	R	Sara d	12 1	ede										

	a 1'01	Department of Health and Menta Certificate of Death	Reg. No. 006 09549							
Physician	1. Decedent's Name (First, Middle, Last)		te of Death onth Day Year / 3. Time of Death							
/Medical	MABEL ZENOBIA CHAMBLEE	Inn	ECH 23 2006 6.20 PM							
Examiner	4a. Fecility Name (If not institution, give street and number)  Lorien @ Riverside	4b. City, Town, or Location of Death	4c. County of Death							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	- 4 - 11 4	te of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)							
Director	251-01-8404 94	Yrs. Worth's Days Flours MAY	4 1911 SOUTH CAROLINA							
show	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits							
e Man iffed ctor	MARYLAND HARFORD CO	JOPPA	1 ☐ Yes 2 🛣 No							
with the Mar n or 28a-f st be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
036  wus after death with the Maryla sair, or items 23s or 28s-1 show Exercitest must be notified at 1 by Funeral Director	405 HAVERHILL RD  11. Marital Status 12. Was Decedent Ever in U.S.	21085  13. Was Decedent of Hispanic Origin? (Specify Y	U.S.A. es or No- 14. Race - American Indian,							
directions or items	Armed Forces?  1 ☐ Never Married 2 ☐ Married   1 ☐ Yes. 2 ☒ No   1 ☐ Yes. Give	If Yes, specify Cuban, Mexican, Puerto Rican,  1 ☐ Yes 2 ☑ No Specify:	etc.) Black, White, etc.							
215-0036 thin 72 hours all walter Even.	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Decedent's Usual Occupation	BLACK							
215-0 215-0 hin 72 ho an "natur	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry							
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	12th grade 6yrs T	EACHER	PHILA PUBLIC SCH SYS							
iryland 212: should be filed within an invested other than matic event, item.	17. Father's Name (First, Middle, Last)	18. Mother's Name (First) ROSA HOLL	, Middle, Maiden Sumame)							
Maryland 212 Maryland 212 d 2 should be filed with th and Mental Hygiene, t7 is marked other than traumatic event, text		Mailing Address (Street and Number or Rural Rout								
Z 5 € 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		05 Haverhill Rd., Joppa	Maryland 21085							
MARKL Baltimore, I Demit. Pages 1 an mportanent of Heal mportanent of them mortanent of each		Disposition (Name of Date y, crematory or other place)	20c. Location - City or Town, State							
Baltimore Baltimore Permit. Pages Department of High Important: If the any injury or or once.	'4 □Donation 5 □Other (Specify)  21. Sign 10 of Funeral Service Licensee	Y NATL CEMETERY 03-28-0  22. Name and Address of Facility	6 BURLINGTON, NEW JERSEY							
Bal Bal Dermi	Darbara C. Drown	WM C BROWN COMMUNITY	FUNERAL HOME-HARFORD P.A. VD, ABERDEEN, MD 21001							
	23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.		ratory arrest, Approximate Interval Between							
Prysician	Immediate Cause (Final disease or condition resulting in death)	10	Onset and Death							
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58760, cate be executed physician and s the burial-transit		м):								
68760, tificate be e: g physician as the buria										
Box 6 leath certific	IF FEMALE: 23b. Was decedent pregnant 1□ Live birth 2□ Fetal death	3 ☐Ectopic pregnancy	23d. Date of delivery  Month Day Year							
of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as a factor. To Be Completed by Physician/Me	in the past 12 menths?  1   Yes   A   Pregnant at time of death	5 Other (specify)	Month Day Year							
is, P.O. I		the underlying cause given in Part I.	Be. Did tobacco use contribute to the cause of death?							
of Vital Records, Physician: The faw requires to this certificate has been signed ral director, page 2 should be to Be Completed by			1 Yes 2 No 3 Probably 4 Unknown							
Record The taw requir te has been s age 2 should		24	ta. Was an autopsy findings available prior to completion of cause of death?							
Vital Relicion: The licion: The haden rector, page			Yes ZONo 1 Yes 2ZONo							
f Vit ysicia iis certi directe	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Out	26. Place of Death (Che	Residence 6 Other (Specify)							
		ime of 28c. Injury at 28d. D	escribe how injury occurred							
Division  To Attending after death. Director: After in by the fune.	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, far	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,							
Division c tall or Attending P is after death. all Director: After I ed in by the funers Certification:	4 Homicide determined building, etc. (Specify)		ty or Town, State)							
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director After	29a. Certifier Certifying Physicien: To the best of my knowledge (Check only Medicel Exeminer: On the basis of examination and	, death occurred at the time, date and place, and du d/or investigation, in my opinion, death occurred at t	e to the cause(s) and manner as stated. ne time, date and place, and due to the cause(s)							
o the ithin 2 o the o the o the omplet	one)  29b. Signature and title a certifier	29c. License number	29d. Date signed (Month, Day, Year)							
F \$ F 0	My MI	060768	3/24/06							
7	30. Name a ddress if person who completed cause of death (Item 23a) (	Type, Print)	Psino Cun, NA 2011							
State	31. Date filed (Month, Day, Year) 32. Watera's Signature —	- 1 Vally of 1	1100 2179							
Registrar	MAR 2 9 2006 Street &	Sparke								

ORIGINAL

06-1913 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,77 pen/F 885/4/27/06 TT State of Maryland Department of Health and Mental Hygiene MICHAEL CLAY For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 2006 0546 A MARCH MICHAEL CLAY /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES 10421 ELDERS HOLLOW DRIVE MITCHELLVILLE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1⊠M 2□F Yrs. NORTH CAROLINA Director 242-04-6937 5-21-1960 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke rthen "naturel", or Iteme 23a or 28a-f ehov the Madical Examiner must be notified at 1X Yes 2 No **Funeral Director** NC MARTIN ROBERSONVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 27871 USA 2521 W. TIMBERLAKE BLVD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CROWELL AND MORING LABORER marked other or 1 and 2 should be fill if the sith and Mental Hy. tem 27 is man 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **EVELYN ANDREWS** GERALD L. CLAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr. any Injury or other treum 2521 W. TIMBERLAKE BLVD. ROBERSONVILLE, NC 27871 EVELYN CLAY-RROWN (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Cemation 3 Removal from State 1√2 Burial 2 □ C 4 □ Donation 5/2 COUNCIL CEM. HWY 11N | 3-21-2006 BETHEL. NC 21. Signature of For eral Service JONATHAN D. HIBNER Name and Address of Facility MANSON MORTUARY, INC. 415 WASHINGTON ST. WILLIAMSTON, NC 27892 23a. Part1. En eithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be deteched f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2□ No Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? 1. Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE ဥ 3 DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) څ 4 | Homicide filled in I within 24 hours e To the Funeral D Medicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 19, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, MARYLAND 21201 Tasha Z Gereen 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAR 2 9 2006

			1 - For State Registrar			nd / Depa		nt of H	ealth and		gien Rag. No	UU	6	09551			
×	Dhyoisi		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	aath Da	av	Year	3. Time of Death			
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	Funeral Director		5. Social Security Number 6. S 224 32 1385	ex 7. □ M 2 1 F	Age (In yrs. 95	last birthday) Yrs.	Months	Days	If Under 24 Hrs Hours Min		th ay, Year 28,1	910	9. Birthp Cour Tenr	place (State or Foreign htry) NESSEE			
	land W		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	10d. Inside City Limits			
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	death me 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in L	J.S. 13.	Was Dece	dent of Hi	spanic Origin? (	Specify Yes or Norto Rican, etc.)	<b>)</b> -			can Indian,			
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "naturel", or iteme 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	No No	1	ir Yes, spe 1 ☐ Yes			no Hican, etc.)			k. White. : Whit				
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	and ealth m 27		Eunice Holderby (	Jaughter,						more, Ma							
Baltimore,	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑	Removal from St	21.1ep	Place of Dispo cemetery, crei			I	Date			-	own, State			
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a											717 3-490			
97		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ————————————————————————————————————													
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48	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. 769	istrar's Sign	ature	porte	b									

		1 - For State Registrar	State of Mary		oartme e <i>rtifica</i>			Mental Hy	/giene	. UUD	09552
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Physici /Medic		Scot Jester Donopl	nan					03-	23	2-06	10 10 01
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and w		10a. State 10b. County	100	. City, Town or	Location						10d. Inside City Limits
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12 st h and 7 is n treun		19a. Informant's Name/Relationship (T) Marjorie A. Donoph						<i>Rural Route Numl</i> ltimore,	-		Zip Code)
permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygiens after death with the Maryla Department of Health and Maralla Hygiens are instured, or items 23s or 28e-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition		Ob. Place of Dis			inde ba.	Date		ocation - City or	r Town State
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_ S S S	ToB	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpati	ent 3 🗆 [	Othe	9r. 4 Nursing	Home 5 ☐ Res	idence	6 □Other (Spr	ecify)
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eath.	atic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(	,,	М		Yes 2 □ No				
r Atta	=	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm,	street, facto	ry, office		28f. Location	(Street an	d Number or R	lural Route Number,
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To the Hospital or Attending Physician: within 24 hours aftar death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy check only one) 1 Medical Exami	rsicien: To the best of my iner: On the basis of exar and manner stated.	knowledge, de mination and/or	ath occurre investigation	d at the tim on, in my op	ne, date and pla pinion, death oc	ice, and due to the curred at the time	cause(s) , date and	and manner a I place, and du	s stated. e to the cause(s)
To t To t	₹	29b. Signature and title of certifier				9c. License				te signed (Mon	
/		I trant	allit. S	WI	>	7)3	6663		Wa	idon	22,2006
n 1		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Typ	e, Print)			5 /	,	,	1215 - 7
		Dr. Stuart Wi	11es 9000	Frank	lin Sq	uare	Drive	Bali	imor	e, Md	21237
Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2005	32. Registrar's S	Signature	alle s						

			1 - For State Registrar	State of M				t of H	ealth a		•		006	09553	
	Physici	an	1. Decedent's Name (First, Middle, Las	st)	>-	CKE	-0				2. Date of De	aath Day	Year	3. Time of Death	
	/Media	al	EVE	UN -		CKE	_	-			MARC.		P		
	Examir	er	4a. Facility Name (If not institution, give	POSPITAL	E =	NT	-		Location of			1	County of Death		
	Funeral		5. Social Security Number 6. S	ex 7. A		last birthday)	_ If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign	7
	Director			□M 25xF	62	Yrs.	Months	Days	Hours	Min.	_16-19	944		yland	
	land ow if		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation			- ,				10d. Inside City Limits	
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	ith the	Funeral Director	10e. Street and Number				10f. Zip	Code	•			10g. Citiz	en of What Cou	intry?	
	ath w	rail	2015 Smith Avenue				2122					U.S.			
	fer de Items	-une	11. Marital Status 1 ☐ Never Married 2∑ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑	?	.S. 13. \	Was Deced f Yes, spec	lent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto P	cify Yes or No lican, etc.)	o- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
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	is 1 and of Health itam 27 othar tr		Leonard F. Decker		20h B				enue I	Lansd	owne M				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐			lace of Dispo emetery, cren t Arun			e) latory.				cation - City or T	own, State	
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Вох (	The law requires that the death certifical tie has been signed by the affending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	3d. Date of deliv	rery	
	deaff	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pre Other (spe						Month	Day Year	
P.0	that the de led by the a		9 ☐ Unknown  Part II. Other significant conditions c		ust not rose	ulting in the us	doshion o		o in Bort I		230 Did	obacco uc	a contribute to	the cause of death?	
Records,	uires t signe Id be c	d by	ASPIRATION	PNEW	rion	CA A	20520	RAZ	Drus		1 🗆			bably 4 Unknown	
CO	aw requir as been si 2 should	Completed	FAILURE: EN	) STAGE	RE	aviti	dis.	- PAC	20,	V	24a. Was		24b. Were aut	opsy findings available	
Re	The lav	mo	HEMODIALISA	· OLD C	CREP	ROMO	Quela	0 1	66.5	2/7	auto perfo 1 ☐ Yes	psy ormed? 2 100	prior to co death? 1 🗆 Yes	ompletion of cause of	
Vital	ysician: is certifical director, p	Be	25. Was case referred to modical examiner?	1						of Death	(Check only				
of	S (4)	2	1 Yes 2 No			ER/Outpatien			4 🗆 IVUI				Other (Speci	fy)	_
	ing Affer une	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	м 2	Bc. Injury Work	at :? /es 2 □ N		3d. Describe	now injury	occurred		
Division	al or Attandi affer death. I Director: A d in by fhe fu	Certification:	3 Suicide 6 Could not be determined		jury - At ho	me, farm, stre	et, factory			28	If Location (	Street and	Number or Rur	al Route Number,	_
	ital or is affe ral Dir led in l	Cert													
	Hospital	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best niner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) a date and p	and manner as a place, and due t	stated. to the cause(s)	
	To the Hospital or At within 24 hours after or To the Funaral Direct completely filled in by	Med	29b. Signature and title of certifier	and manner st			29c.	License	number			29d. Date	signed (Month,	Day, Year)	
	. , , , , ,			Men	$\overline{}$	mg	$) \mid $	91	1950	02	_	MA	1CH 2	4, 2006	
	3		30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)		Non	Hav	JZ .	4881	1774	4, 2006 Canzon 0 21133	
			31. Date filed (Month, Day, Year)	32. Registr	rar's Signat	ture		R	الملك	41152	DelN	de	dry Colo	0 21193	
	Sta Registr	4	MAR 2 9 200		A A	Ann	A D								
			JULY & STATE	1	7	Call Special	O. King								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 196, per fin 8854 4-3-06 vt ealth and Mantal Hygiana and M

	1- State Registrar		artment of Health and rtificate of Death	_	giene	09554
	Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
Physician /Medical	Fred Gordon Dense				26, 2006	10:00P M
Examiner	4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of De	ath	4c. County of	Death
	Manor Care-Potomac		Potomac		Montgo	omery
uneral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours Mi	n. (Month. Da	v. Year)	Birthplace (State or Foreign Country)
ector	Usuel Residence of Decedent	73 Yrs.		July 3	1, 1932	Ohio
any injury or other traumatic evant, the Mudical Examiner must be multified at once.  To Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
Ö	Maryland Montgomery	Bethesda				1 ☐ Yes 2 🙀 No
Director	10e. Street and Number	Dechesaa	10f. Zip Code		10g. Citizen of Wh	nat Country?
	6203 Stoneham Road		20817		United :	
Funeral	11. Marital Status 12. Was De		Was Decedent of Hispanic Origin?	(Specify Yes or No	- 14. Race	- American Indian,
	1 Never Married 2 Married 1 Dayes	2 No Varage	f Yes, specify Cuban, Mexican, Pu	erto Hican, etc.)		White, etc.
1 by	3 Widowed 4 □ Divorced Year or	Dates: Conflict	1 ☐ Yes 2 ☒ No Specify:		Specify:	White
Completed by	15. Decedent's Education (Specify only highest grade completed	f) (Give	dent's Usual Occupation kind of work done during most of w	vorking	16b. Kind of Bus	iness/Industry
mpi	Elementary/Secondary (0-12) College	(1-4or 5+) life.	DO NOT use retired)			
	4	Admi	nistrative Offic			Health Service
Be	17. Father's Name (First, Middle, Last)			ame (First, Middle,		
은	Charles Fred Dense			lle Steph		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or a Baldridge	Rural Route Numbe	er, City or Town, S	tate, Zip Code)
	Catherine T. Goldberg/D  20a. Method of Disposition	20b. Place of Disno	Bardridge Circle			y Land ZI/UI ity or Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ Removal from	cemetery, crer	natory or other place) Apr Heaven	cil 1,	200. LOCATION - O	ity of Town, State
	`4 □Donation 5 □Other (Specify)	Cemet	erv   200	06	Silver S	pring, MD
	21. Signature of coneral Service License	Be	Name and Address of Facility Ro thesda-Chevy Cha thesda, Marvland	ase. Inc.	7557 W	runeral Home/ isconsin Avenu
_	/ Cuche lan					
	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.	er the mode or dying, such as card	ac or respiratory ai	rest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	tastatic 90	enal cell ca	ncer		3.03. 4.13 334.1
	Due to	o (or as a consequence of):				Estatus
10	Sequentially list conditions, if any, leading to immediate Due to	o (or as a consequence of):				
Examiner	Cause (Disease or injury that initiated events	(0. 40 4 0011004001100 01).				
Xai		(or as a consequence of):				
dicai E						
a a	u					
Physician/M		utcome of pregnancy			23d. Date	of delivery
cia	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		Monti	n Day Year
hys	9 □ Unknown 9 □ Unk	nown				
by P	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
				1 🗆 1	/es 2 □ No 3	Probably 4 Unknown
Completed				24a. Was		ere autopsy findings available
mo			·		rmed? pri	or to completion of cause of ath?
a	25. Was case referred to medical		26 Place of D	1 ☐ Yes eath (Check only o		Yes 22(No
OB	examiner? Hospitat	Inpatient 2 ER/Outpatien	Other	Home 5 Resid		(Specify)
-	27. Manner of Death 28a. Date	e of Injury 28b. Time of	28c. Injury at		now injury occurred	
atio	1 ⊠Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Certification:		ce of Injury - At home, farm, str	eet, factory, office			or Rural Route Number,
Sert	4   nomicide buil	ding, etc. (Specify)		City or Tow	m, State)	
edical (	(Check only 2 Medical Examiner: On the	basis of examination and/or in-	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
Med	one) and ma  29b. Signature and title of certifier	nner stated.	29c. License number		29d. Date signed (	'Month, Day, Year)
	N.S.		0005456	Į.	3)27/01	
				6	7/- //01	0
	30. Name and address of person who completed cal			1)	T. 0 0	A4 D 2 1 2 C 4
	31. Date filed (Month, Day, Year)  MAR 2 9 2006	Begistrar's Signature	JUPPA ROOD, Su	H230	1000 SON	1, 1912/286
ate trar	MAR 2 9 2006	A Appeal				
Line .	DULLE / . M / HHH # #####	FULL F.				

			1 - State Registr Amend Item		of Marylar						ental Hy	gien	. U U	6	095	555
	Dhyoisi	0.00	Decedent's Name (First, Middle,	Last)	t MIM DI	<del>) 60)3</del>	<del>-)  4</del> ;	<del>7/00 -</del>	Jn		2. Date of De	ath		Year	3. Time o	of Death
	Physici /Medio		Earl C. Dyer				T				March 7	7, 2	006		5:30	) a <sup>M</sup>
}	Examin	er	4a. Facility Name (If not institution, Holy Cross Hosp	-	umber)				Location o				c. County o			
	Funeral		, ,	6. Sex	7. Age (In yrs.	last birthday)	1		pring		8. Date of Bir		ontgo		lace (State	or Foreign
	Director		577-12-6839	1 🕅 M 2 🗆 F	87	Yrs.	Month	Days	Hours	Min.	8. Date of Bir (Month, Da 1 / 9 / 1 9 1	ay, Year L9	) W	Coun	ngton	
	pu >		Usual Residence of Decedent  10a. State 10b. County	-	10a C	ty, Town or Lo										
	Aaryla F show	ō		gomery	1	Silver		ng						1	0d. Inside ( 1 ☑ Yes	s 2 No
	28a-	Director	10e. Street and Number					ip Code				10a. C	itizen of Wi	nat Coun		
	h with		531 Randolph Ro	oad Apt#3	310 B			0904					nited		•	
	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or iteme 23a or 28a-f show ent, the Mudical Examinar must be multiled at	Funeral	11. Marital Status		cedent Ever in U		Was Dec	edent of Hi	ispanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race	- America White, e		
36	or its	by F⊔	1 Never Married 2 Marrie	ed 1 ⊠Yes If Yes, G	2 □ No UII. iive	Λ.		2⊠ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	110411, 010.7		Specify:			
Ö	hour:	ed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's	Year or	Dates:	16a. Dece	dont's He	ual Occupa	ation			165 6	Kind of Bus			
5	nin 72 n "na Nedic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed		(Give	kind of v	vork done d use retired	turina most	t of workin	ng	100. 1	Nina oi bus	messind	ustry	
212	d with	Com	Elementary/Secondary (0°12)	1	(1-4or 5+)	Dist	ribu	tor				Di	istril	outio	on	
_	0 = 5	Be (	17. Father's Name (First, Middle, L								(First, Middle		n Sumame	)		
<u>S</u>	2 should be and Mental ie marked o raumatic eve	٦ ا	Earl Walter Char		<u> </u>	1					eld Dy					
Maryland 21215-0036	d 2 st th and t7 ie n traun		19a. Informant's Name/Relationsh Donna Klein / Ca		or		-				<i>l Route Numb</i> d floo:					20050
ā,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked eny injury or other traumatic especies.		20a. Method of Disposition	ise Hallag	20b. I	Place of Dispo	sition /N	ame of			ate		ocation - C			20030
Ê	Page: ient of nt: if i		1 ☐ Burial 2 ☐ Cremation → ☐ Other (Sp.		Jale	cemetery, crer	matory of	otner place	θ)							
altimore,	mit. partm porta y inju		21. Signature 1 Fureral Service L			r 26	3 Name &	and Addres	e of Facility	Board	d 655 W	J. B.	altim	ore	Stree	t
<u> </u>	\$0 E 2 B		mount.	11/h	(fl)			imore	•	2120						
			23a. Part 1. Enter the disease, or of shock or heart failure. List of	omplications that nly one cause on	caused the deal each line.	th. Do not ent	er the mo	ode of dying	g, such as	cardiac oi	r respiratory a	rrest,			Approxima Interval Be	etween
,	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Seps:	İs	177-1-17									Onset and	Death
	/Medical Examiner		resulting in death)		(or as a consec											
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U.	ary trac		CLIO	n								
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	â												
Ď,	e exected and and arrial-tr	Exa	resulting in death) Last	Due to	(or as a consec	quence of):										
8/60	The law requires that the death certificate be executed the hes been signed by the attending physicien and vage 2 should be detached for use as the burial-transit	dicai	•	d							<u> </u>					
×	eath certific attending p	/Me	IF FEMALE:	23c If yes o	utcome of pregna	ancy						* I				
X R R	atten atten I for u	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live	birth 2 Feta	al death 3	Ectopic Other (	pregnancy specify)					23d. Date Mont		ry Day	Year
oj.	at the de by the de stached	hysi	9 Unknown	9□ Unki	nown			,,,								
ο, J	res tha	by P	Part II. Other significant condition		death but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco	use contrib	ute to th	e cause of	death?
ord	w require been si	ted	Acute renal far								1 🗆	Yes 2	!□No 3	Proba	ably 4 🔀	]Unknown
Hecords,	e 2 sh	npie	Respiratory fa	ilure							24a. Was	psy	24b. We	ere autop or to con	sy findings	available cause of
											1 ☐ Yes	ormed? 2⊠ No	de	ath? ] Yes		
Vital		o Be	25. Was case referred to medicat examiner?  1 ☐ Yes 2 ☒ No	Hospital:	u	1550		Othe	· F*		(Check only o					
	<u>a</u> = <u>a</u>	<b>-</b>	27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of		28c. Injury Work	4 🗀 Nui		ne 5 Resi				)	
0	트 등 둑	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	nth, Day Year)	Injury	М		? ∕es 2 🗆 N	No						
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	of be 28e. Place	e of Injury - At h	ome, farm, str	eet, facto	ry, office		2	8f. Location (: City or To			or Rural	Route Nur	mber,
ב	pitel c															
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the to	Medicai	29a. Certifier 1 ☑ Certifying (Check only one) 2 ☐ Medical E	Physicien: To the xaminer: On the l	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	n occurre vestigatio	d at the tim n, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s date an	s) and man d place, an	ner as sta d due to	ited. the cause(	(s)
	To the To the Complet	Me	29b. Signature and title of certifier		1101 314100.		2	9c. License	number			29d. Da	ate signed (	Month, E	Day, Year)	
	0		> Kuly	Aa	M		-	D323	332			03	3/08/	2006		
			30. Name and address of person	no completed cau		п 23а) (Туре,	Print)									
			Suresh K. Gupta			Georg	jia A	ve St	e# 22	20; S	ilver	Spr	ing, 1	Mary	land	20902
i	Sta Registr	te ar	31. Date filed (Menth Pay Year) MAR 2 9	2006	Registrar's Signa											

				artment of Health and Mental Hyg ertificate of Death	giene 006 09556
	Physic		Decedent's Name (First, Middle, Last)     Naomi	Ellington 2. Date of Dea	
ì	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Baltimore    If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day   Min.   0.7   1.5	9. Birthplace (State or Foreign Country) NC
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L.		10d. Inside City Limits
	e Mary	ctor	MD NA Baltim	ore	<b>X</b> ∑Ves 2 □ No
	with th	I Director	10e. Street and Number 3802 Lyndale Ave	10f. Zip Code 21213	Og. Citizen of What Country?
36	72 hours after death with the Maryland *neturel", or Itams 23s or 28s-f show adical Examinar must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes You No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
215-003	72 hour	ted t	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
2121	within 9ne. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired) ecretary	State of Maryland
Maryland	id be filed ental Hygi ked other c event, I	To Be C	17. Father's Name (First, Middle, Last) Charlie Thomas	18. Mother's Name (First, Middle, I	
ary	2 should and Men ie marke aumatic	ř		ng Address (Street and Number or Rural Route Number	
	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition  20b. Place of Disposition  1 ★ Burial 2 Cremation 3 Removal from State	matory`or other place)	20c. Location - City or Town, State
Baitimore,	permit. Pag Department Important: eny Injury once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility arch F/H West	altimore Co, Md
			23e Part 1 Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	300 Wabash Ave, Balti ter the mode of dying, such as cardiac or respiratory arm	est, Approximate
,	Physician /Medical Examiner		Immediate Cause (Final	ra of Breast	Interval Between Onset and Death
/	uted d ansit	mlner	Sequentially list conditions, if any, leading to immediate cause. Litter or unarrying Cause (Disease or injury that initiated events		
8/60,	icate be executed physicien and s the burial-transit	dical Examin	resulting in death) Last  Due to (or as a consequence of):  d.		
^	e death certif he attending led for use as	Physiclan/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
ords, P.	80 E 6	by	Part II. Other significant conditions contributing to death but not resulting in the un		acco use contribute to the cause of death?
Deco	To the Hospital or Attending Physician: The law requir within 24 hours atter death.  To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should	Completed	Diabetes Mesletie	24a. Was an autops: perform	24b. Were autopsy findings available prior to completion of cause of death?
NI A	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one	
5	iding Phys th. After this funeral dir	tlon: To	1 Pes 2 No Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation  Hospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation		nce 6 Sother (Specify) + 0 126 winjury occurred
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structured building, etc. (Specify)		eet and Number or Rural Route Number, , State)
	he Hospit in 24 hours he Funers pletely fille	edlcal	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death only one)  Certifying Physicien: To the basis of examination and/or invanient stafed.	n occurred at the lime, date and place, and due to the ca yestigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. ite and place, and due to the cause(s)
	To t To t com	×	29b. Signature and title of certifier  Was ESS.		nd. Date signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type,	Printle 2 11-21	13/26/2006 UPEE, MPZ1207
	Sta		31. Date filed (Month, Day, Year)  MAR 2 g 2006  32. Registrar's Signature	WOVIDA SI, PAULIK	ruce, Mychar
	Registra	ar	MAR 2 9 2006		

			For State Registrar	State of I	Marylan	-	artmen rtificate				-	giene Reg. No.	306	095	57
	Physici	an	1. Decedent's Name (First, Middle,		-						2. Date of De. Month	Day	. Year	3. Time o	
	/Medic	al	4 P. W. M. W.			Fulto		T		(0	MARCI		2006		AM
	Examin	er	4a. Facility Name (If not institution,	TALTH CAR		0.000	_		Location of			40.0	County of Death	1	
	Funeral			Sey 7		last birthday)	If Under	1 Year		24 Hrs.	8. Date of Birt	th	9. Birth	nplace (State	or Foreign
	Director		218-26-7005	1□M 20F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 3-24-	-1930	) Coi	Md	
	put 🛦		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	cation							10d. Inside 0	Sibr Limite
	daryla f sho	ō	Md	N/A		Balto	odion								2 No
	28a-	Director	10e. Street and Number	11/21		Darto	10f. Zip	Code	5			10g. Citiz	en of What Co	untry?	
	h with		3027 W. Lanvale	Street				2	1216			-	SA	•	
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show the Medical Extendent for notified at	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White		
36	or it	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 [ If Yes, Give	ZNo		1 ☐ Yes		Specify:		1 110411, 0101,		Canaifu		
00	hour tural'	ed b	15. Decedent's	Year or Date:	s: 	16a. Dece	dent's Heus	A Occupa	ation	,			B J	Lack	
15	n "na	Completed	(Specify only highest Elementary/Secondary (0-12)	am da ao malatad)		(Give	kind of wor DO NOT us	rk done d se retired	furing mos )	t of work	ing	Seni		npan <b>i</b> or	1
212	giene. grene. er thar	ĕ	10th grade	College (1-4c	N/A		Seni	or C	ompan	ion			Servic	•	
nd	be filed within 7. tal Hygiene. d other than "n event, ile Medi	Be (	17. Father's Name (First, Middle, La Charles Andrew								e (First, Middle,	Maiden S	Sumame)		
yla	should be and Mental smarked c umatic eve	၉							Mazi						
Mai	2 8 8 E		19a. Informant's Name/Relationship Rodney Tynes - 1								al Route Numbe			ip Code)	
ē,	as 1 and 2 should of Health and Men item 27 is marke r other traumatic		20a. Method of Disposition	5011	20b. P	lace of Dispo	Sand	ne of	- 1		Balto		21207 ation - City or 1	Town, State	
OL	m O .		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		te	emetery, crei	-		. !				allstow		21215
Baltimore, Maryland 21215-0036	그는만급	li	21. Signature of Funeral Service Lie			ing Mer	noira . Name an	L Pat d Addres	rk s of Facilit	3-2	9-2006 ch F/H	Wes		,	21213
ä	Depa Impo any ir		Juan B.	aknum	-1/10		4300	) Wa	abash	Ave	nue B			215	
			23a. Fart1. Enter the disease, or shock, or heart failure. List or	omplications that caus	sed the death	n. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory ar	rest,		Approxima Interval Be	tween
	Enysician	4.5	Immediate Cause (Final disease or condition	CA	mac	steer	,	16	wi		eller			Onset and	.Death
	/Medical Examiner		resulting in death)	Due to let	as a consequ	uence of):	- 7	7	E	1					
		<u>.</u>	Sequentially list conditions,	b. Due to (or	38 3 GUNESQI	marca of	ufo	ene							
T	uted d ansit	Examiner	Sequentially list conditions, I any, Isaum at immuniate cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , , ,											
, O	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or a	as a consequ	uence of):									
8760,	cate be executed physician and s the burial-transit	dical		d											
9	death certificate e attending phys d for use as the	Med	IF FEMALE:	00-16											
Вох	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal	Idéath 3□	Ectopic pro					23	<ol> <li>Date of deliver</li> <li>Month</li> </ol>		Year
o.	that the de ad by the detached	iysid	1 □ Yes 2 <del>□ N</del> o 9 □ Unknown	9□Unknown		eatti o	J Other (spi	вспу)							
Δ.	requires that the een signed by th nould be detache	by Pr	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.	,	23e. Did to	bacco us	e contribute to	the cause of	death?
rds	w require been sig should bi	ed b	Mejela	013/36	aste	1	rem	us.			1 🗆 Y	/es 2 □	No 3□Pro	bably 4	Unknown
Records,	aw is b	Completed		50							24a. Was		24b. Were aut	opsy findings	available
	The ate h page	E C									perfor	rmed?	death?		Jause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						-1000	of Death	(Check only o	ne)			
of	hys this al diu	2	1 Yes & No	Hospital: 1 ☐ Inpa		ER/Outpatien			NI NI		me 5 Resid			ify)	
	ding l h. After funer	tion	27. Manner of Death  1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigal		Day Year)	28b. Time of Injury	M Z	Bc. Injury Work	at ? ′es 2 ∐ !		28d. Describe h	iow injury	occurred		
Division	Attending r death. ector: After oy the fune	fica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of I	Injury - At ho	me, farm, str					28f. Location (S	Street and	Number or Rur	al Route Num	n <i>ber</i> ,
ā	s afte	Certification	4  Homicide	building,	etc. (Specify	/)					City or Tow	in, State)			
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the be- aminer: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) a date and p	and manner as a	stated. to the cause(s	s)
	To the To the Comp	M	29b. Signature and title of certifier	h			29c.	License	number		-	29d. Date	signed (Month,	Day, Year)	
	(			1	e		1	بدر	564	4	477 a miles	51	28/00		
	4		30. Name and address of person who was the state of the s	o completed cause of	f death (Item	23a) (Type, Law ture	Print)	ed,	7-	En	, Pa	1	BAZ	FD MI	)
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 2 9	2006 32. Regis	strar's Signat	ture	week	9		7					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 FRANIC **Physician** GERNARD 0321 M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/24/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**2** M 2□F Director 217-05-9367 86 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 Cecil Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 at Hygiene. Department Elementary/Secondary (0-12) College (1-4or 5+) Construction Management 8 of the Navv 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other treumetic event 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Frank Kate Kleiderlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Doris Craig/Wife 126 Cecil Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/28/06 Baltimore, MD Holy Cross Cem 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityG.J.Gonce Funeral Home, <u>Riviera Drive, Pasadena, MD</u> 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Week /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed transit rer and g physicien an Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes ☐ No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 Yes 2 No 2 Accident investigation within 24 hours after deat To the Funerel Director: completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) 0 21438 who completed cause of death (Item 23a) (Type, Print) DEYENSE HIGHWAY ANNAPOLISMO 21401 ENMM al 441 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 19a oer Th 8853 3-31-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 19arch 25, 2006 **Physician** Martin Adrian Fox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner land Greneral timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Oate of Birth (Month, Day Year) April 16, 1945 Balto., MD 6 Sax 9. Birthplace (State or Foreign **Funeral** Days 1 ₹M 2 □ F Hours Min Yrs. 60 Director 218-44-6817 Usual Residence of Decedent 10b Counts 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Mudical Exercities must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Dundalk Ave., 2nd floor 21222 U.S.A. items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. XXNever Married 2 Married ö White 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r International Elementary/Secondary (0-12) College (1-4or 5+) unknown Merchant Seaman Seafares 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Pappa Mathias Fox 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a important: If Item 27 is any injury or other tra Mary Thomas 6212 Fortview Way, Baltimore, MD 21224 <del>/Sister</del> Baltimore, 20a. Mathod of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of unk. Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Baltimore, MD 21. Signature of Juneral Service Incepsed 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the ettending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No. 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 2 No director. 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ N 1 Dipatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident i Director: / d in by the f 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

9 2006

32. Registrar's Signature

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ma	ryland / I	Departme Certifica			Mental Hy	giene Reg. No.	16	09560
	Physic		Decedent's Name (First, Middle, La     ESTHER			FRIBUSH	1		2. Dete of De Month Which	Dey	Year 006	3. Time of Death
<u>&gt;</u>	/Medi Examir Funeral		4a Fecility Neme (If not institution, giv KESWICK NURSING 5. Social Security Number 6. 8	HOME 7. Age	(In yrs. last bi	rthday) If Unc	ler 1 Year		Location of Deat  IMORE  8. Date of Bir	th 4c. County	of Deeth	N/A place (State or Foreign
,	Director		Usual Residence of Decedent	□M 2 7 F	96	Yrs.			JUL.27	,1909		MD
	Marylar Fred at	tor	MD N/A		10c. City, Tow	n or Location BALTIMO	RE.					10d. Inside City Limits 1
	with the	Director	10e. Street end Number	DOAD			Zip Code			10g. Citizen of	What Cou	•
20	be filed within 72 hours efter death with the Maryland ritel Hygiene.  ad other than "natural", or Herne 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	3400 LABYRINTH  11. Marital Status  1 Never Merried 2 Married  3 10 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1  Yes 2 X No If Yes, Give			edent of F becify Cubi	2121 dispenic Origin? (San, Mexican, Puer Specify:		5 14. Rac Blac Specifi	ck, White,	USA can Indian, etc. WHITE
21215-0020	nin 72 hour n "natural" Wedical Es	Completed b	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's Us (Give kind of v life. DO NOT	sual Occup work done use retired	eation during most of wo	rking	16b. Kind of B		
6.4	should be filed within and Mentel Hygiene. marked other than imatic event, the M	Com	Elementary/Secondary (0-12)	College (1-4or 5+	SE	AMSTRES	S	18 Mother's Na	me (First Middle	CLOTHII		
⊑	should be ind Mentel imarked o umatic eve	To Be	NATHAN			YOLKEN		EVA			NEW	BERGER
	2000		19a. Informent's Name/Relationship ( BARBARA BASIK /					and Number or Ri GHTS AVE.		-		MD 21208
an .	Pages 1 and 3 sent of Health int: If Item 27 iry or other trans		20e. Method of Disposition 1		20b. Place o cemete	f Disposition (N ry, cremetory of ISRAEL	ame of other plac	ce)	Date	20c. Location -	City or To	own, State
Balti	permit. Pages Depertment of Important: If it any Injury or o		21. Signature of Funeral Service Licen	Hee Whater		22. Name	and Addre	ss of Fecility	SOL LEVI	NSON & E	BROS.	
)	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	· Era-st	age		Ma		c or respiratory e	rrest,		Approximate Interval Between Onset and Death
x 68760,	v requires that the death certificate be executed been signed by the attending physician end should be detached for use as the burial-trensit	8	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c		consequence of						
. Box	death o	sician	Part II. Other eignificent conditions or		not resulting in	n the underlying	cause giv	en in Part I.	23b. Did	tobecco use cor	ntribute to	the cause of death?
ς, Γ.	is that the gned by the se detach	oy Phy	Diabetes mellete		I							babiy 4 🗆 Unknown
or vital Records, P.O	Ine law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Completed by Physician/N							24a. Was perfo	an autopsy ormed?	ava	ere autopsy findings ailable prior to mpletion of cause death?
	in: The		25. Was case referred to medical					26 Place of Pag	ath (Check only o		1[	]Yes 2□No
V TO HOL	or attending Prystotan: The law effer death.  Director: After this certificate hes In by the funeral director, page 2	၉	examiner?  1  Yes 2 No  27. Meny of Death  1  Natural 5  Pending 2  Accident investigation	Hospital: 1  Inpatient 28e. Date of Injury (Month, Dey )	28b. 7		28c. Injun Work	er: 4 Nursing H	lome 5□ Resid	dence 6 Other		y)
- ;	vithin 24 hours effect de Within 24 hours effect de To the Funeral Directo completely filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (	(Specify)				City or Tov			
3	within 24 hours of To the Funeral D completely filled i	edicai	29a. Certifier 1 ✓ Certifying Phy (Check only one) 2 ☐ Medical Exam	relcien: To the best of r Iner: On the basis of ex and manner state	camination and	, deeth occurred d/or investigatio	d et the tim n, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as st	ated. the cause(s)
1	withi To th		29b. Signature and title of certifier  M. Isabelle 76	a Quana	1 6 X		C. License			29d. Date signed		
,	6		20. Name and address of access who a		th (Item 23e) (	T D-1-0	D 136					we 6
	Stat	e	MARELLE V) Be 31. Date filed (Month, Day, Year)	GREGOR, 70	Signature	The SIR	EET,	15HL/11)	roke, VI	90121	1	
	Registra	ar	MAR 2 9 2006	1800000	J. A.	R. C. L.						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Registra Amend Item #5,6,7,&10e&f Per GAT 168359 3129756 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year galloway -235 PM March ean 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Battmore
If Under 1 Year | If Under 24 Hrs. Williago tuture Came harles 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M AH 50 11956 **Funeral** 10 M 20 49 Days Min Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f shov Tre Medical Exaginer must be notified at Baltmone 1 Yes 2 No Completed by Funeral Director MD 10e. Street and Number 2451 Barclay ST. 10f. Zip Code 21218 10g. Citizen of What Country? 154 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cleak OFMO - Court t. Pages 1 and 2 should be filed withen of Health and Mental Hygie rtant: If item 27 is marked other tilliury or other traumatic event, in other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be · UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any injury or other trau
once. Spinner Bultimore MD Derotha Bonday 2451 81515 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Donil 4, 2006 Zlan Can 22. Name and Address of Facility
Hari D. Cose Fin
5126 Belain Road 21. Signature of Funeral Selvice Licensee Service P.A. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACQUIRED SYND ROME DEFICIENCY IMMUNE /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, sician Physiclan/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably # Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? E No 1 Yes 1 ☐ Yes 👢 🚧 🗸 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide the Hospital filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 00058457

Registrar

DHMH 17 Rev 1/2001

State

NAVA

31. Date filed (Month, Day, Year)

NORTH

2. Registrar's Signature

FUTAW

STREE

BACTIMORE 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CEASAN

MAR 2 9 2006

			For State Registrar	State of Maryla		artment of Health a rtificate of Death	and Mental H	ygiene Reg. No. 0 0 6	09562
	Physici	an	1. Decedent's Name (First, Middle	John	Grima	ıldı	2. Date of D Month	Day Year	3. Time of Death
	/Medic	al	Saverio  4a. Facility Name (If not institution		GLIME	4b. City, Town, or Location o	March	1 23,2006 4c. County of Death	1:30a <sup>™</sup>
	Examin	er		Adventist Hos	nital	Takoma Pa	_	Montgome	
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs	s. last birthday)				place (State or Foreign
	Director		579-24-1014	12X1 M 2□F 80	Yrs.	Moritis Days Hours	1/12	/1926 Wash	D.C.
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation			10d. Inside City Limits
	Mary f sho	tor	MD Prine	ce George's	Adel	lphi			1 ☐ Yes 2 X No
	h the	irec	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	ntry?
	23e c	Funeral Director	9817 26th Av	renue		20783		USA	
	er des	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces? 122 Yes 2 \( \t \) No 1 9	U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	14. Race - Ameri Black, White,	
36	hours after death with the Maryland turel', or Items 23e or 28e-1 show al Exament for notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	It Yas Giva	44	1 ☐ Yes 2X No Specify:		Specify: W	hite
21215-0036	d within 72 hours after death with the Marylan jiene. r then "neturel", or Items 23e or 28e-1 show The Mudical Exama reconstites at	ted	15. Deceden (Specify only highe	t's Education	16a. Dece	dent's Usual Occupation	t of working	16b. Kind of Business/in	dustry
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during most DO NOT use retired)		5	5
121	e filed withi I Hygiene. other ther		17. Father's Name (First, Middle,	(ast)	, s	pecial Agent	r's Name <i>(First, Middi</i>	Dept.of	Delense
Maryland	d la la	To Be	Paul Grimal				gelina De		
ary	2 should by and Menta is marked sumetic e	-	19a. Informant's Name/Relations			ng Address (Street and Numbe			Code)
	is 1 and 2 of Health a item 27 is other tree			rimaldi/Wife		7 26th Avenu			
ore	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Bemoval from State	cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or To	
Baltimore,			* 4 ☐ Donation 5 ☐ Other (S 21. Signatur ☐ neral Service			Washington		Adelphi, M	
Ba	permit. Departr Importe eny inji		I Make ()	melt.	9	HTTTP ABORTINA 241 Columbia	Blvd.Si	lver Sprin	g,Md20910
Ų			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused the deconly one cause on each line.	ath. Do not en	ter the mode of dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a Due to (or as a conse	augustas att	2 Spiraton	1 for	live	
r	Examiner			Cox	Ci w	ama Lin	MP		
	± g	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consa	querice oty:	2	1		
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Statu	-1 /	05+ Ce	rebyo V	a s caled	
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687	ficate p phys ts the	edical		d					
Вох	death certific e attending pl id for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi		∃Ectopic pregnancy		23d. Date of deliv	
	0 0 0	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown	ons contributing to death but not re	eulting in the	anderhing source groon in Dort I	23e Dio	I tobacco use contribute to t	he cause of death?
of Vital Records,	w requires that the been signed by th should be detache	ted by	Fatti, Ottor significant conduct	one contributing to death but not re	ssutting in the t	indenying cause given in Part i.		Yes 2 No 3 Prol	
ecc	law as b	Completed					24a. Wa	opsy prior to co	opsy findings available ompletion of cause of
E B		Con					per 1 \( \text{Yes}	formed? death? 2₺ No 1☐ Yes	2□ No
Zit	Physicien: This certificate al director, p.	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital:	7500		of Death (Check only		
of		-	27. Manner of Death	1 Minpatient 2	28b. Time o	f 28c. Injury at		sidence 6 Other (Special books) occurred	7/)
ion	Attending F r death. ector: After by the funer	atlo	1 Accident 5 Pending investig		Injury	Work? M 1 ☐ Yes 2 ☐ h	No		
Division	al or Attene after death Director: d in by the	ertification:	3 Suicide 6 Could determ		home, farm, st cify)	reet, factory, office		(Street and Number or Run own, State)	al Route Number,
	To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the best of my kr Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the	e cause(s) and manner as s e, date and place, and due t	stated. o the cause(s)
	To the l within 2. To the I complet	Me	29b. Signature and ville of certifie	1. 1		29c. License number	( )	29d. Date signed (Month,	
)				67 D		D0060	100	03-2	3-06
	10		30. Name and address of person	who completed cause of death (Ite		Print) 00 Carroll A	venue Tal	koma Park.M	Id20912
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2	32. Registrar's Sign	n n turn				
		-		7-2000	- /2		_	10.53	

			For State Registrar		State of	Marylar	nd / Depa <i>Ce</i>	artment o <i>rtificate</i>	of He	alth and eath	d Mental F	lygien Reg. N		16	09563	· Link
	Physic	an	Decedent's Name (First		t)						2. Date of Month		ay	Year	3. Time of Death	_
V	/Medi	cal		ammer				45 O'S T			Month MAF		26,	2006	7:00 A	M
	Examir	ner	4a. Facility Name (If not in Saint J				nter	46. City, 10	wn, or L	ocation of De	vson	46	c. County	of Death Balt	imore	
	Funeral Director		5. Social Security Number 213 09 31%	1 (	x 7. X M 2□ F	Age (In yrs. 94	last birthday) Yrs.			f Under 24 H Hours M		Birth <i>Day, Year</i> y 31 1	912	9. Birthpi Coun Lando	lace (State or Foreigntry) Wer, MD.	gr
	and and		Usual Residence of Dece 10a. State 10b.	County		10c. Ci	ty, Town or Lo	cation						11	0d. Inside City Limit	te
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	h the	lrec	10e. Street and Number					10f. Zip Co	ode			10g. C	itizen of \	What Coun		-
	ath wi	ralD	5810 Westwood	Avenue				2120	6			US	A			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f show early flurry or other treumatic event, the Madical Examiliar must be notified at ADDS.	by Funeral Director	11. Marital Status  1 □ Never Married 2  3 ★ Widowed 4 □ □	_	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ⊠X¥lo		Was Deceden If Yes, specify 1 ☐ Yes 2√2		panic Origin? Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		ce - America ck, White, e	etc.	
2	72 ho	eted	15. D (Specify onl	Decedent's Edi ly highest grad	ucation		16a. Dece	dent's Usual C	Occupations du	on	vorkina	16b. F	Kind of B	usiness/ind		_
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<u>a</u>	id be lental ked o ic eve	To Be	Walter Franki		ar-						ne Chaney	Jie, maidel	ii Suman	16)		
ary	and M and M amar	-	19a. Informant's Name/R		_		19b. Mailir	ng Address (S	treet and	d Number or	Rural Route Nui	nber, City	or Town,	State, Zip	Code)	_
	and 2 ealth a n 27 i		Connie King (	(Daughtei	<u>c)</u>		-			ue Bal	timore, M	1.2120	6			
Baltimore,	ges 1 t of H if Iter		20a. Method of Disposition 1 X Burial 2 ☐ Crer		Removal from Sta	1 ,	Place of Dispo cemetery, crer	sition (Name inatory or othe	of r place)	l I	Date	20c. L	ocation -	City or To	wn, State	
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Ba	Depermine Deperm		21. So ature of Funeral S	thon	ha Par	3	I	assahn I	Tuner	al Home	Inc					
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9		Med	IF FEMALE:		_											_
XOX	death certifi e attending I od for use as	Physician/Me	23b. Was decedent pregrin the past 12 month	ant	23c. If yes, outcor 1☐Live birth	2 Feta	I death 3	Ectopic pregn				ľ	23d. Dat	te of deliver	ry Day Year	
o i	0 0	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□Unknowr		eath 5∟	Other (specif	(y)			-			July 104	
7	requires thet the peen signed by th hould be detache	by Ph	Part II. Other significant of	conditions co	ntributing to death	h but not res	ulting in the ur	nderlying caus	e given	in Part I.	23e. Di	d tobacco	use cont	ribute to the	e cause of death?	_
ğ	w require been sig should b										1]	Yes 2	□No	3 🗆 Proba	ably 4 DUnknow	'n
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ľ	The lay	Con									pe 1 ☐ Yes	rformed?	0	death?		
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<u> </u>	r Attending er death. rector: After by the funer	텵	1 XNatural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, I	Day Year)	Injury		Injury at Work?	2 □ No	200. 2000110	o 11011 11170	ry occum	00		
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5	rs after aft				No.											
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)	ertifying Phy- ledical Exami	sician: To the be ner: On the basis and manner	st of my kno of examina stated.	wledge, death tion and/or inv	occurred at the estigation, in r	ne time, my opini	date and place on, death occ	ce, and due to the curred at the tim	e cause(s e, date and	) and ma d place, a	nner as sta and due to t	ited. the cause(s)	
	Within To th Comp	¥	29b. Signature and title of	certifier (	7			29c. Lie	cense n	umber		29d. Da	te signed	d (Month, D	lay, Year)	_
			• 40	The state of the s	Q			D	26	002		3/2	2,66	,		
	12		30. Name and address of	person who co	empleted cause o	f death (Iten	23a) (Type, i	Print)								_
	1		31. Date filed (Month, Day		I FR. J	R. y	LD. 7	601 0	SLE	R DRI	VE, TO	WSON	, M	ARYL	AND 2120	Zì
	Sta Registr	re .			Sz. Megi	on an a signa	lui B	J								
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DHMH 17 Rev 1/2001

ORIGINAL

Darren Green UNK 06-02080 NJM

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			ene	Ū6	0956	i
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day	Year	3. Time of Dea	th
	/Media	cal	DARREN GR					March		2006	0149	М
	Examir	ner	4a. Facility Name (If not institution, given Johns Hopkins Hos 5. Social Security Number 6. So	pital	(la una la at historia	Baltimo	r Location of Death  Ore  If Under 24 Hrs.	0.00	4c. County	A	(0)	
	Funeral Director			DM 2□F 7. Age X	21 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y MAY 24,	1984	Oount MD .		eign
	yland now		10a. State 10b. County		10c. City, Town or L	ocation			·	10	d. Inside City Lir	nits
	e Mar	ctor	MD. N/A		BALTIMO	RE					1XÕYes 2☐	No
	vith th	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of V	What Count	ry?	
	eeth v	Funeral	1200 TREE LEA	F COURT  12. Was Decedent B	ever in ILS 13	Was Decedent of H		acity Yes or No.	USA 14 Bac	e - America	an Indian	
920	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2/7 N If Yes, Give Year or Dates:	lo	If Yes, specify Cuba 1 ☐ Yes Ž☐ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Blac	k, White, e	itc.	
2-0	72 hor nature	eted	15. Oecedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation	na 16	b. Kind of Bu	usiness/Ind	ustry	
21215-0036	iene. r then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ONE	during most of worki i)	9	NONE	2		
שַ	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)			ONE	18. Mother's Name	(First, Middle, Ma				
Maryland	should but nd Ment	2	DARREN GRE		400 04 11			A BLACK				
Ma	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship (7) LORRETTA BLACK				and Number or Rura		TO ME		.202	
Baltimore,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Disp		! 0	-	c. Location -	City or Tox	wn, State	
Ë	Pages ment of ant: if it		1 □terial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		1	N CEMETI		.5,2006	BALT	O,ME		
Ball	permit. Pag Depertment Important: i eny injury o		21. Ignature of Funeral Service Licen	See	d		ss of Facility SCRUGG					
		10	23a. Part1. Enter the disease, or comp	olications that caused	the death. Do not en	412 E I	PRESTON  g, such as cardiac of	ST. BAL	TIMOF	RE,ME	Approximate	_
-	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each lin		6-1111	het Wo	rude			Interval Between Onset and Death	1
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	LAdminer	_	Sequentially list conditions,	b	consequence of):							
0	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	`								
o,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of):	***						
8760,	cate by physic the bu	dica	•	d								
9 X	death certificate e attending phys	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d Dat	e of delive	v	-
Box	death ne atter	Physician/Medical	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Mo		Day Year	
P.O.	The law requires that the de ste has been signed by the a bage 2 should be detached	Phys	9 ☐ Unknown  Part II. Other significant conditions co		t ant consisting in the .		on in Book I	230 Did toba	200 440 240	abuta la thu	e cause of death	
	uires ti signe Id be c	d by	ratti. Ottor significant conditions (	onthibuting to death of	ic not resulting in the t	indenying cause give	en an Faiti.	1 ☐ Yes	V		ibly 4 Unkno	
COL	s been si should I	Completed						24a. Was an	24b. \	Vere autop	sy findings availa	able
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/ita	Physicien: Th this certificate ral director, paq	Be	25. Was case referred to medical examiner?			Tou	26. Place of Death	1		4		
of	Physic r this c ral dir	5	Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	444		4   Nursing Hor	me 5 Residence			)	
ion	Attending r death. ector: After by the funer	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	3/25/1	Year) Four	. /A Worl	Yes 2 (No	Suh		Shor	<u> </u>	
Division of Vital Records,		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	ry - At home, farm, st . (Specify)	reet, factory, office	11	281. Location (Street City or Town,	et and Numb	er or Rural	Route Number plejeat	CA
	the Hospital or hin 24 hours after the Funeral Dir npletely filled in		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of		truent 1	ulding		150	etiv	hove u	D
	To the Hospital within 24 hours a To the Funeral completely filled:	edical	(Check only Medical Exam	iner: On the basis of and manner sta	examination and/or in	vestigation, in my or	pinion, death occurre	ed at the time, date	and place,	and due to	the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	-1	^	29c. License			. Date signed			
			- Caral	Hall	Lacuny	oci	ME	Ma	rch, 2	25, 20	JU6	
	I		30. Name and address of person who d	completed cause of de	eath (Item 23a) (Type,		nn Street	Rol+imo	oro M	arw1 ar	nd 21201	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Ragistra	r's Signature		mi prieer	Dalumi	11 6 LIC	л у та	21201	
	Registr		MAR 2 9 2	006	w & A	neck			100			
DH	MH 17 Rev 1/2	001		1	- 7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item #23a 27 pen/E, C853,320/06 IT State of Maryland Department of Health and Mental Hygiene 06-02127 Kellsie Glenn 1 - For State Registrar **RJD** Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 27, 2006 Year **Physician** 0249 A. M KELLSIE GLENN /Medical 4a. Facility Name (If not institution, give street and number)
Greater Baltimore Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 5 Yrs. Director 218 59 4034 NOV. 20,2000 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show MD. Director N/A 1 Yes 2 □ No BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2704 KING RIDGE RD. 21234 USA r death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) at Hygiene. N/A PRE K N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental H 27 is marked of r trsumatic ever Pages 1 and 2 should be KEITH GLENN ERICKA HAMLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Heelth an Importent: If Item 27 is eny injury or other trausonce. 2704 KINS RIDGE RD. ERICKA HAMLIN (MOTHER) BALTO, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 3/31/06 BALTO, MD. Jonature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. 21213 BALTO, 23a. Part1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) a. Anomaious coronary arteries (left main arising from pulmonary trunk) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached Ó Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ certificete has been sign rector, page 2 should be 1 ☐ Yes 2 💢 o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \square No 24a. Was an autopsy performed? Division of Vital 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 Inpatient 2 2 △ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 XNatural 5 Pending death. М 1 Tes 2 No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	Olate of Maryland		e of Death	Reg.	4000	09566
Physic /Medi		1 Decedent's Name (First, Middle, Las	FARRISON			2. Date of Death Month	Pay LYear	3. Time of Death
Exami		4a. Facility Name (If not institution, give NORTH WEST HOS	Street and number) CEN	TER RAN	Town, or Location of De		4c. County of Dea	
Funeral Director		201-12 6601	7. Ago (In yrs. In	ast birthday) If Under Months	1 Year   If Under 24 H Days Hours Mi		9. Bin 9. Si	thplace (State or Foreign
8 Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  BA14:1	noke 10c. City	BAIF, MC	re			10d. Inside City Limits 1 ☐ Yes 2 ◯ No
uth with the 23a or 28 ust be no	Funeral Director	190. Street and Number 1428 CAPPOII	Street	10f. Zip	Code 31230	10g.	Citizen of What Co	ountry?
Ind 21215-0036  be filed within 72 hours after death with the Maryland lial Hygiene. d other then "natural", or iteme 23a or 28a-f show event, ira Mudical Examinat must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Deced If Yes, spec	dent of Hispanic Origin? offy Cuban, Mexican, Pur No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify:   S	
d 21215-( filed within 72 h Hygiene. ther then "natu int, the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wor life. DO NOT us	rk done during most of w	rorking 16b	Fire K	Industry
Maryland 212' d 2 should be filed within th and Mental Hygiene. 77 is marked other then treumatic event, tra M	To Be	17. Father's Name (First, Middle, Last)  AMES HARR	SON			ame (First, Middle, Maid ers E	en Sumame)	
Nd 2 3			ison - Wife	1428 CA	RROll S	Pural Route Number, Cit BaH	y or Town State, 2	Zip Code) 21230
Page Page ment of ant: if		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,  21. Signature of Funeral Service Licens	Removal from State	ace of Disposition (Namered or of Disposition (N	ne tery	106 LA	nderin	Town, State
Bait. Permit. Depentimports any inji	9 9	Wethich N	1. William	0 2140	Address of Fictor	n Ave BAI	to, Md	21217
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line.  a. Due to (or as a consequi	AIN	e of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	ner	if any, leading to immediate	b Due to (or as a conseque					
icate be executed physician and sthe burial-transit	ai Examin	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseque	ence of);				1
E ora	Wedicai	IF FEMALE:	d					
LIVISION OF VITAL RECORDS, P.O. BOX 08/06 Within Expension of Attending Physician: The law requires that the death certificate be within Expenses after death. To the Expenses Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burners.	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal o 4□Pregnant at time of dea 9□Unknown	death 3 Ectopic pre			23d. Date of deli Month	ivery Day Year
Tus, F		Part II. Other significant conditions co END STAGE RE	VAL DISER	ts &	iuse given in Part I.	23e. Did tobacc		the cause of death?
VICAL RECOPCES, Ician: The law requires t certificate has been signe	Completed by	LEREBROVAS CU HYDERTERSION	MAR Acci	2512		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
cian: 1 cian: 1 ertifice actor, p	BeC	25. Was case referred to medical examiner?				1 ☐ Yes 2 ☑ eath (Check only one)	√o 1 ☐ Yes	2□ No
Physi Physi rthis c	 1	1 ☐ Yes 2 No 27. Magner of Death		R/Outpatient 3 DO		Home 5 Residence		city)
VISION OF VITA Attending Physician: or death. ector: Atter this certifica by the funeral director, i	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	3c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how in	ury occurred	
UNISION tal or Attending rs after death. al Director: Afte ed in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory,	office	28f. Location (Street City or Town, Sta	and Number or Ru ite)	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in it	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my know ner: On the basis of examinatio and manner stated.	ledge, death occurred a on and/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the cause curred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
with Con	Σ	29b. Signature and title of certifler	PHYSICIAM	29c.	D42783	m A	Pate signed (Month RCM & 6	Day, Year 2006
3		30. Name and address of person who co	HARISH		SAOI O	LA CONUL	ROAD	mp 2/133
Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registrar's Signatu	Localis				
DHMH 17 Rev 1/20	001		Seal of the seal o	4				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment of H tificate of L				ene g./No.00	6	095	67
	Physici /Medic		1. Decedent's Name (First, Middle, Las Elsie Mae Hastings	•						Date of Death Month March	Day	Year 006	3. Time of 9: 45	f Death P M
	Examir		4a. Facility Name (If not institution, give Waldorf Nursing Ho		er)		4b. City, Town, or Wald		of Death		4c. Count	y of Death	1	
	Funeral Director		411 14 9902	DM off	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, b. 4, 19	Year) 19	9. Birth Cou Ten	nplace (State ountry) NESSEE	or Foreign
	death with the Maryland ime 23s or 28e-f show f must be notified at	or	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Mary	/S		y, Town or Lo	cation CSVille						10d. Inside C	ity Limits
	or 28e-	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	intry?	
	ath w	ra	39044 Holly Drive				20659				USA	A		
980	be filed within 72 hours after death with the Marylan ital Hygliene. ad other than "natural", or items 23s or 28e-f showevent. Its Madical Exeminer must be nullified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 WiDivorced	12. Was Decede Armed Force 1 Tyes 2: If Yes, Give Year or Date	s? XNo	1	Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2⊠ No	spanic Origin, Mexican Specify:	n, Puerto Ric	/ Yes or No- an, etc.)		ck, White	ican Indian, , etc. hite	
Maryland 21215-0036	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		or 5+)	(Give life. (	lent's Usual Occupa kind of work done of DO NOT use retired Mail Cler	luring mosi )	t of working	1	6b. Kind of B		ndustry	
1d 2	be filed within tal Hygiene. d other than event, Ir a Ma	Be Co	17. Father's Name (First, Middle, Last)	I		1	all Clei		er's Name (F	irst, Middle, M				
ylaı	2 should be and Mental Is marked or reumatic even	To E	Maynard M. Hickle 19a. Informant's Name/Relationship (7)	Sunn Outed		405 14 11	111 (2)		nith D					
, Ma			Kenneth Hastings			1	g Address (Street a Holly Dr							9
Baltimore,	permit. Pages 1 and Department of Heal Important: If itsm 2 any injury or other once.		20a. Method of Disposition  1		to Ce	emetery, cren	sition (Name of natory or other place 1 Mem. Ga.		Date 3/30,		oc. Location Baltimo			nd .
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licen	rkousk	le le	22 I	Name and Addres Bruzdzins 1407 Old	s of Facilit ki Fu Easte	neral ern Ave	Home Fenue Es	A. sex, N	Maryl	and 21	221
1	Physician		23a. Pa/t1. Enter the disease, or comp thock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that cause on each	sed the death line. 244 E	n. Do not ente		, such as		spiratory arres	st,		Approximat Interval Bet Onset and	ween
	/Medical Examiner		resulting in death)	Due to (or	a Consequ	uence of):							0	•
	cuted td ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequ	ranca of).								
8760,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or	as a consequ	uence of):								
.O. Box 6	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ XNo 9 □ Unknown		2 Fetal	death 3	Ectopic pregnancy Other (specify)					te of delive	,	Year
rds, P	quires that in signed b	þ	Part II. Other significant conditions co	Sion			derlying cause give	n in Part I.		23e. Did toba	cco use con		the cause of d	
Division of Vital Records,	The law requir	Completed	Anxily	disa	~ 25/	2				24a. Was an autopsy performs			opsy findings ompletion of c	
<u>ta</u>		Bec	25. Was case referred to medical examiner?					28. Place	of Death (C	heck only one			2010	
<u>&gt;</u>	Physicien: r this certific ral director,	2	1 ☐ Yes 2 🗷 No	Hospital: 1 🗌 Inpa	atient 2 🗆 E	ER/Outpatien	: 3□ DOA Othe	r: 4 <b>⊠</b> Nui	rsing Home	5 🗌 Residen	ce 6 □Oth	ner (Speci	fy)	
sion c	To the Hospitel or Attending Physicien: whithin 24 hours after deals. To the Funersi Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1		njury Day Year)	28b. Time of Injury	28c. Injury Work M 1 \( \text{Y}	at ? 'es 2□!	No	Describe how				
DIX	itel or Att urs after d ret Direct lled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of	Injury - At horetc. (Specify	me, farm, stre	eet, factory, office		28f.	Location (Stre City or Town,	et and Numb State)	oer or Rur	al Route Num	ber,
	To the Hospitel or within 24 hours after to the Funeral Director Completely filled in the completely filled in the	Medical	29a. Certifier 1⊠ Certifying Phy (Check only onle) 2 ☐ Medical Exam	ysician: To the be iner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at the tim estigation, in my op	e, date and inion, deat	d place, and th occurred a	due to the cau it the time, dat	se(s) and ma e and place,	anner as : and due I	stated. to the cause(s	;)
	To the Comp	W	29b. Signature and title of certifier	41.1			29c. License	number		290	d. Date signe	d (Month,	Day, Year)	4. /
	ın l		30. Name and address of person who o	completed cause of	f death (Item	23a) (Type. I	Print)	444	136	//	MAKC	٨ -	1/2	006
	IV		Ashvin J. PAL	1 102	PAUL	1 me	29c. License	*	102 6	Unla	het.	mo	306	02
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		for State	State of M	arylani			ate of L			7.2	MAG	09568
		Registrar  1. Decedent's Name (First, Middle,	Local		Ce	Tunca	ale or L	Jeani	2. Date of De	Reg. No	000	3. Time of Death
Physic	ian			in T	7. ~ i	_	Lin	2100	Month	Da		
/Medi	cal	CAND			2126		176-	trris	03	2		M_525:01
Exami	ner	4a. Facility Name (If not institution,				4b. Cit	ty, Town, or	Location of Dear	th		ince Geo	
*		LAUREL REG. 1 5. Social Security Number			ast birthday		AURCI der 1 Year	If Under 24 Hrs	9 Date of Bi			
Funeral Director		576-80-5074	1 □ M 2 🔀 F	51	Yrs.	Month		Hours Min		1954	Lib	rthplace (State or Foreign Country) eria
Royal Co		Usual Residence of Decedent										
yland		10a. State 10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
Mar.	ţċ	Maryland Montgome	ry	Silve	er Spri	ng						1 Yes 2 □ No
h the	Director	10e. Street and Number				10f. 2	Zip Code			10g. Ci	tizen of What C	Country?
h wit		2507 Musgrove Road				209	04			U.S.A		
dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Dec	cedent of Hi	spanic Origin? (S	Specify Yes or Norto Rican, etc.)	o-	14. Race - Am Black, Wh	
after or Its	正	1 Never Married 2 ☐ Marrie					2M No		nto riican, etc.)		Specify: B1	•
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or Itema 23a or 28a-f ehow int, the Marical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			1 0 1 0 3		Specif.			Specify:	
72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	kind of v	sual Occupa work done o	during most of wa	orking	16b. K	(ind of Busines	s/Industry
ithin and and and and and and and and and an	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT	use retired	)				
Dallillore, Mal ylatin Z IZ 13-0030 bernit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or mny highly or other traumatic event, the Medical Examples.	S	12			None			45.44.4. 1.11	(F)	Non		
m 0 5	Be	17. Father's Name (First, Middle, L	as <i>t)</i>						me (First, Middle		n Sumame)	
Idy yidilid Z IZ 13-00000 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f ehow aumatic event, Ita Macilcal Examinar must be notified at	2	Unknown			T				ncis Tubma			
raum		19a. Informant's Name/Relationshi				_			lural Route Numb			Zip Code)
Definition of the permit Pages 1 and 2 should by Department of Health and Menta Important: If them 27 is marked any injury or other traumatic expose.		Crystal Harris, Daug	hter	20h Pi				4	con, Virgi			r Tour State
S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	B □Removal from State	200. F1	ace of Dispermetery, cre	matory o	r other plac	θ)	Date	200. L	ocation - City o	TOWN, State
tmen tant		4 Donation 5 Other (Sp.		Nati	onal Ci				h 29, 2006			, VA
ermii Depar Depar Depar Depar		21. Signature of Funeral Service L	censee		2				leck Fune			
2 002 60	-	Clasandra	- grate	2					ig Road, L		, Maryla	·
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each li	a the death ine.	. Do not en	ter the m	ode of dying	g, such as cardia	ic or respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_ aMetastat	ic Rect	tal Can	cer						2 Months
/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
	_	Sequentially list conditions,	b		area aff							
ed sit	lne	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury										
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ifficate g phys			d.									
eath certific attending pl	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv						23d. Date of de	olivoo
eath cert attending for use	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetaf	death 3[	Ectopic Other	pregnancy (specify)			1	Month	Day Year
hat the de	ıysi	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown									
# # B #	y P	Part II. Other significant condition	s contributing to death b	out not resu	fting in the u	underlying	g cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
uires Id be	d by								1 🗆	Yes 2	□No 3□F	Probably 4 \Unknown
w require been signatured should b	ete								24a. Was	an	24h Were	autopsy findings available
The lav	Completed						·		auto		prior to death?	completion of cause of
stcian: Th certificate rector, pag		25 Mas sace referred to medical							1 ☐ Yes		1 ∐ Ye	s 2X No
or Attending Physician: The law requires taller death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?  1  Yes 2 No										
Par age	. To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		DOA	4 1401311191	28d. Describe			өспу)
ding Ph th. After th funeral	후	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Natural 5 Pending 2 Accident investigation							· ·			
or Attending after death. Director: After in by the fune	flca	3 ☐ Suicide 6 ☐ Could no	t be 390 Place of In	ury - At hor	me, farm, st	reet, fact	ory, office		28f. Location (	Street al	nd Number or F	Rural Route Number,
after d	Certification:	4 Homicide determin		tc. (Specify,			,		City or To	wn, Stati	9)	
Hospital Pours 5 Funeral Itely filled		29a. Certifier 1X Certifying	Physician: To the best	of my know	vledge, deat	th occurre	ed at the tim	ne, date and place	e, and due to the	cause(s	) and manner a	as stated.
To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examinati	ion and/or in	vestigati	on, in my or	oinion, death occ	urred at the time,	date an	d place, and du	e to the cause(s)
To tha within 2 To the comple	₩	29b. Signature and title of certifier	) VA , No	A		2	29c. License	number		29d. Da	ite signed (Mor	nth, Day, Year)
, , , , ,		► Kr#	my /w	7)			D53987			Marc	h 22, 200	06
4		30. Name and address of person w	ho completed cause of o	death (ftem	23a) (Type.						_,,	
		Dr. Kenneth Geh, 30					e. MD 1	20201				
St.	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signat	ure		∠ الناو ــ					
Regist	rar	MAR 2 9 201	16	80	Acort	20						

			1 - For State Registrar	State of Marylar		ent of Healtlate of Dea			ene	5 095	69
			Decedent's Name (First, Middle, Last,	)			2	2. Date of Death	1	3. Time o	of Death
	Physici /Medio		Desideria T. Har	t				Month MALCU	- 0	706 813	30 PM
	Examir		4a) Facility Name (If not institution, given DA + MOVELUAS) 5. Social Security Number 6. Se	street and number)	Las Burdey Cir und		DUN der 24 Hrs. 8	Date of Birth	4c County of		nede
	Director		219-74-2309	JM 2 <b>1</b>	Yrs. Month	s Days Hou		(Month, Day, lar. 12	1933	Phillipi	ines
	pu »		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Location					1011-111	
	ehov	5			•					10d. Inside C	s 2X No
	28e-f	Director	MD Anne A	rundel		n Burnie		1.4	0.000		
	a or	늅		7.0	TOT. 2	Zip Code		10	ig. Citizen of Wh	States	
	eath	era	313 Hospital Dri	ve 12. Was Decedent Ever in U	IS 13 Was Dec	2106		fy Yes or No-		- American Indian,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If learn 27 is marked other then "natural", or iteme 23a or 28e-f ehow any injury or other treumatic event, the Maryland Examinar must be notified at once.	by Funerai	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 27 No If Yes, Give Year or Dates:	1	pedent of Hispanic pecify Cuban, Mexi 2 XNo Spec		can, etc.)		White, etc. White	
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7	ed wi	Completed	8		Clea	ner			Janitor	ial	
2	d off	Be	17. Father's Name (First, Middle, Last)			18. Mo	other's Name (i	First, Middle, M	faiden Sumame)		
<u>₹</u>	ould Men warke	၉	Crisanto	TOTTOTO				nciana	Unknov		
Jai	2 sh and is m	1	19a. Informant's Name/Relationship (Ty		19b. Mailing Addre	ss (Street and Nur	mber or Rural F	Route Number,	City or Town, St	ate, Zip Code)	
e)	l and lealth im 27		Dorothy Byrum D  20a. Method of Disposition		236 Wand		Pasaden   Dat				
0	it of h		1 ABurial 2 ☐ Cremation 3 ☐ F	lemoval from State	Cler haven	r other place)				ity or Town, State	
₫	it. Pa rtmer rtant njury		Donation 5 Other (Specify)	M	lemroial Pa		3-28-2		Glen I	Burnie, M	D
Ba	Depa Impo Impo Iny i		Signatura Vineral Service Llos	MINOUNIN	13/1/	and Address of Fa					
			23a. Part 1. Enter the disease, or compl	ications that caused the dea		Hammonds				Approxima	ite
1	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	VENMONIA			ospiratory arro	J.,	Interval Be Onset and	tween
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			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
penno	ficate be executed physicien end is the burial-transit		Cause (Disease or injury that initiated events c.								
0	e exe ien ei urial-t	E	resulting in death) Last	Due to (or as a consec	quence of):						
8760,	ate b hysic the bu	dicai		J							
<u> </u>	entific ling p	Mec	IF FEMALE:								
P.O. Box	the death certific y the attending p ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 Ectopic				23d. Date of Month	,	Year
Vital Records, P	I RECORDS, P.O. BOX 68/60,  The law requires that the death certificate be executed ate has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	5	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying	cause given in Pa	art I.			ute to the cause of	death?
ပ္ပ	s been si should	jet					/	24a. Was an	24b. We	ere autopsy findings	available
æ	The tay te has age 2	Completed						autopsy	ed? dea	ore autopsy findings or to completion of cath?	cause of
ā	tor, p	0	25. Was case referred to medical			26. Pl	lace of Death (			Yes 2 No	
$\geq$	Physician: r this certifica ral director, I	To B	examiner? 1 Yes 2 No	lospital:	ER/Outpatient 3□ [					(Specify)	
0	PP		27. Manner of Death	28c. Injury at Work?	4 Nursing Home 5 Residence 6 Other (Sp. 28d. Describe how injury occurred						
Ö	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	! □No					
Division of	tal or Att	Certification:	3 Suicide 6 Could not be determined	28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2   Medical Examination one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date on, in my opinion, o	and place, and death occurred	d due to the car at the time, da	use(s) and mann te and place, and	er as stated. d due to the cause(:	s)
	To T	2	29b. Signature and title of certifier	0	2	9c. License numbe	er		1	Month, Day, Year)	-
)			· Dec	U_		10055	703			L 23, 20	10 G.
	\		30. Name and address of person who co	5 - 7- / 1	m 23a) (Type, Print)	1701	6	r 2 1	it m	.1	
	\		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Victo Ct.	N7272	OLEN	Buken	ic m	5	
ì	Sta Registr		MAR 2 9 20		b. beek	p .					

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 20a per fh 8853 3-29-06 vt
Amend item 20a per Markland 19853 3-29-06 vt
Amend item 20a per Markland 19853 3-29-06 vt For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 25. Geraldine Jacobs March 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Genisis Hamilton Nursing Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2√2 F Director 438-40-7025 75 March 13,1931 LA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-1 show Examiner must be notified at 1 Yes 2 No Director N/A New Orleans LA. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Items 23e 8212 Willow 70118 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Creole þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) College Inn

18. Mother's Name (First, Middle, Maiden Surname) 12th cook 17. Father's Name (First, Middle, Last) Be Piccola James Jacobs Zenno ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1226 N. Spring St. Baltimore, Md 21213 Frances Harris/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ot riel 2 Cremation 3 Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) Providence Mem.CemAprill,2006Mataire, LA. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CALVIN E. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BRAIN **Physician** AND METASTATIC. resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of) use as the burial-Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pelli within 24 hours To the Funerel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the PHYSICAN 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title visce DOD 62239 MARCH, 28,0006 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) MARC MAING OU MD SAL ARLLON 1211192 GOOD , 11425 W. Orgo 32 egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2006 Registrar

		For State Registrar	State of Mary	land / Depa <i>Cer</i>	tificate of I			Reg. No.	306	09572
Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Day	Year	3. Time of Death
Physicia /Medic		James Robert Kell	ey				Mar.		006	7:30A M
Examin	er	4a. Facility Name (If not institution, give s	treet and number)			Location of Death	1		unty of Death	
		524 Old Home Rd.	15.0		Baltimore		100 - 40		ltimore	
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da March 2:	ay, Year)	_ Cour	place (State or Foreign htry) West Virginia
Director		236 22 4822 X	. 02				I'BLUI Z	J 1724	Wald	, west virginia
/land		10a. State 10b. County	10	c. City, Town or Lo	cation				1	Od. fnside City Limits
Man	to	Maryland Baltimore		Baltimore (	County					1 Tes 2 No
72 hours after deeth with the Maryland natural, or Iteme 23a or 28a-f ehow dical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number			10f. Zip Code				of What Cour	ntry?
th wil	a	524 Old Home Road			21206			USA		
eep	Iner	11. Maritaf Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14.	Race - Americ Black, White,	
or it	포	1 ☐ Never Married 2 ဩ Married	1 X Yes 2 ☐ No If Yes, Give		Yes 2 XNo	Specify:			ecity: Whi	ito
ural'.	D P	3 Widowed 4 Divorced		W II	lastic Havel Oscur	-1:	,	10h Vind	of Business/in	
"nat	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done OO NOT use retired	durina most of wor	rking	160. Kind	or pressure	dustry
within ane. then	Ē	Elementary/Secondary (0-12)	Coflege (1-4or 5+) NA		Machinist			Johns H	Honkins I	University
Hygic Hygic ent, II		17. Father's Name (First, Middle, Last)	1411		· · · · · · · · · · · · · · · · · · ·	18. Mother's Nan	ne (First, Middle			
id be ental ked o	To Be	Homer Hobart Kelley				Katherine	S Wild	ner		
should and Men marke umatic		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numb	er, City or To	wn, State, Zip	Code)
and 2 salth a n 27 ie		Barbara T Kelley (Wi	fe)	524 (	Old Home Ro	ad Baltim	ore, Mary	Land 212	206	
tem tem tem		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Locat	ion - City or To	own, State
Page nent of nt: if		1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Most Holy I			8 2006	Baltim	ore, Mary	land
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiane. Department of Health and Mental Hygiane.  Beginnerant: If term 27 is marked other then "natural; or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.	1	21. Signature of Funeral Service License	90	A 22	Name and Addre	ss of Facility	\h			
Depermine Permine Perm		Matha 1080	than Chario	7/	Ol Belair	Road Baltir	more. Mars	vland 21	236	
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	death. Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory a	arrest,	1	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CHANN	IC INT	MSTIT	IM EI	B121515			Onset and Death
/Medical		resulting in death)	Due to (or as a co				13.003.12			
Examiner	L	Sequentially list conditions,	)							
st ad	<u>n</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence of):						
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ettending pt for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d	. Date of deliv	ery
o ette	clai	in the past 12 months?	1 Live birth 2 ☐ 4 ☐ Pregnant at time		]Ectopic pregnancy ] Other <i>(specify)</i>	/			Month	Day Year
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igned by the e	by P	Part II. Other significant conditions con					23e. Did	tobacco use	contribute to t	he cause of death?
been signature of the state of	ed	CHWAIL DASPM	10DUE PM	MUNM	y DISIM	55	10	Yes 2 X	lo 3 ☐ Prol	bably 4 □Unknown
	Completed						24a. Was		4b. Were auto	opsy findings available ompletion of cause of
The The ste he	mo						perfe	ormed?	death?	2 No
r this certificete hes aral director, page 2	BeC	25. Was case referred to medical				26. Pface of Dea	ath (Check only			
G S	To	examiner? 1 ☐ Yes 2 X No	lospital: 1   Inpatient	2 CER/Outpatier	nt 3□ DOA Oth	er: 4 ☐ Nursing H	lome 5 Res	idence 6	Other (Special	fy)
T = E		27. Manner of Death 1 SNaturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	f 28c. Injur Wor	rk?	28d. Describe how injury occurred			
<b>5 9 9</b>		2 Accident investigation			M 1 🗆	Yes 2 □ No				
ending sath. or: Afte he fune	atle	3 ☐ Suicide 6 ☐ Could not be	28e. Pface of Injury building, etc. (5	At home, farm, sti Specify)	eet, factory, office			(Street and Nown, State)	lumber or Run	al Route Number,
or Attending ter death. Irector: After or by the fune	rtificati	4 ☐ Homicide determined								
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Hospital or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune		29a. Certifier (Check only 2 Medical Exami	sician: To the best of m	amination and/or in						
thin 24 hours after death.  the Funerel Director: Afte mpletely filled in by the fune		29a. Certifier (Check only one) (Check only one)		amination and/or in		opinion, death occu		, date and pla		o the cause(s)
within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical Certificati	29a. Certifier (Check only 2 Medical Exami	ner: On the basis of ex	amination and/or in	vestigation, in my o	opinion, death occu		date and place 29d. Date s	ace, and due t igned (Month,	Day, Year)
within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier (Check only one)  29b. Signature and title of certifier	ner: On the basis of example and manner stated	amination and/or in	29c. Licens	opinion, death occu		date and place 29d. Date s	ace, and due t	Day, Year)
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			For State Registrar	State of Marylar		artment of F	lealth and l	Mental Hy	giene Reg. No.	) U 6	095	73
			1. Decedent's Name (First, Middle, Las		1			2. Date of Dea	ath Day	Year	3. Time of	
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	Examin		4a. Facility Name (If not institution, give				r Location of Deat	h		County of Death	2 T	
			SOLOMONS NURSIN  5. Social Security Number  6. Se		last hirthday)	If Under 1 Year	MONS If Under 24 Hrs.	8 Date of Birt				r Fornian
	Funeral Director		577-26-9340	8 M 2□F 8 D	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	192	3 Virg	place (State o ntry) ginia	roleigh
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					I0d. Inside Ci	ty Limits
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:	or 28e	Director	10e. Street and Number			10f. Zip Code	- 4		10g. Citiz	en of What Cou		
	23a vi		13325 DOWELL	KV,		206				( 4	ATES	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	- 1	<ol> <li>Race - American Black, White,</li> </ol>		
336	hours after death with the Maryland turet', or Items 23a or 28e-f show Lever it et mast be melling at	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ZÄYes 2 ☐ No If Yes, Give Year or Dates: WWI	I	1 ☐ Yes 2 🂢 No	Specify:			Specify: whi	lte	
21215-003	n 72 hours after death with the Maryian "naturel' or Items 23a or 28e-f show		15. Decedent's Ed	ucation		dent's Usual Occup		rking	16b. Kir	d of Business/In	dustry	
215	filed within 72 Hygiene. Ither then "nai ent, ILe Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	d) -	King				
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and a	e d all all all all all all all all all a	Be	17. Father's Name (First, Middle, Last)			unk		ne <i>(First, Middl</i> e, or Kent	maiden s	sumame)		
Maryland	s 1 and 2 should be t Health and Mental item 27 Is marked o other treumatic ev	2	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Maili	ng Address (Street			er. Citv or	Town. State. Zit	Code)	
	nd 2 ilth a 27 ls r trei	,	Jeanette Woodruff		1	14 Wood S				19	,	
ē,	s 1 ar		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other place	1	Date		ation - City or To	own, State	
Ë,	Pages nent of ent: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	in state	•	, ,						
Baltimore,	permit. Pages Department of I Importent: If its any injury or o		21. Signature of Funeral Service Licens Ronald S	wade lipecto	r Si	2. Name and Addre tate Anat altimore,	ss of Facility omy Boar MD 212	d 655 W.	Ba1	timore S	Street	
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F	Physician	1	Immediate Cause (Final disease or condition		ive h	eart -	anlore			3	Onset and E	
	/Medical		resulting in death)	a Due to (or as consec	quence of):						-74	~ / /
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	ted sit	Examiner	cause. Litter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):							
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							
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89	tificat og phy as th	_						-				
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	230. was decedent pregnant	23c. If yes, outcome of pregn 1□Live birth 2□Feta		Ectopic pregnancy	,		2	3d. Date of delive	,	/ear
		slcl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of o 9□ Unknown	death 5	Other (specify)				Month	Day Y	eai
0.	hat th ed by detacl	Phy	Part II. Other significant conditions co	intributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to t	he cause of d	eath?
ds,	The law requires that the site has been signed by the page 2 should be detached.	d by			Ü	, ,		1000	res 2	]No 3 ☐ Prot	pably 4 ⊡U	Jnknown
000	w require been si should I	Completed						24a. Was	an	24b. Were auto	psv findings a	available
e R	he la e has age 2	dwc	-					autop	rmed?	prior to co death? 1 ☐ Yes	mpletion of ca 2□ No	ause of
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>	nysica nis cen direc	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpaties	nt 3 DOA Oth	er: 4 Nursing H	lome 5 🗆 Resid	dence 6	Other (Specif	y)	
Division of Vital Records,	ding Pl h. After th tuneral		27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe h				
<u>s</u>	r Atten ter deal irector: by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and vn, State)	Number or Rum	Al Route Numi	ber,
<u> </u>	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifics completely filled in by the funeral director, it		29a. Certifier 1 Certifying Phy	vsician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and place	, and due to the	cause(s)	and manner as s	tated.	
:	the H the Fi the Fi	Medical	one)	iner: On the basis of examina and manner stated.	and and or in							
1	Vit Con Con	2	29b. Signature and title of certifier	Q -41		29c. Licens				signed (Month,		
			30. Name and address of person who d	Bennett M.C	)_ m aac\	Deina)	5136		/VIG	ch 20,	2006	
			Charles W-Be	ennett M.D.	118 4	5 True	man Rd.	, 401	1641	Md. 20	0657	7
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registrar's Sign	ature	ورث ا						

			1 State Registrar Amend Item  1. Decedent's Name (First, Middle, Last	State of Marylan	d / Depa 3 3 /29	artment of F	lealth and Death		Reg. No. UUO	09574
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Carlos Lamont	Lewis	-,,			2. Date of De Month March 2	Day Year	3. Time of Death 2:27a. M
)	/Medic Examir		4a. Facility Name (If not institution, give University of Mary		Center	4b. City, Town, o	or Location of De	ath	4c. County of De	
	-uneral Director			7. Age (In yrs. 21	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. 8. Date of Bin (Month, Da Apri I	th y, year) <b>1984</b> 9. B	irthplace (State or Foreign Country) Md
Maryland	a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md	N/A	y, Town or Lo Ba	cation altimor	e			10d. tnside City Limits TE Yes 2 □ No
th with the	23a or 28a	Funeral Director	10e, Street and Number 2633 Puget Str	eet		10f. Zip Code	2123	О	10g. Citizen of What 0	Country? USA
.1.2.1.3-0030 within 72 hours after deeth with the Maryland	Department of results and wealther register; or fleme 23a or 28a-f show the contract. If them 27 is marked other than "naturel; or fleme 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	ğ	11. Maritat Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	l:	Vas Decedent of H f Yes, specify Cuba	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
<b>7.13-7</b> Thin 72 ho	e. Medical	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of w	rorking	16b. Kind of Busines	s/Industry
Maryland Z 1 Z 1 3-0036 nd 2 should be filed within 72 hours af	ental riggient ked other the ic event, he	To Be Con	11th  17. Father's Name (First, Middle, Last)  Carl Lewis			Cook		ame (First, Middle, a Bourba	Mc Dona Maiden Sumame) aur	lds
and 2 should be	27 is mar rtraumat	-	19a. Informant's Name/Relationship (Ty Ellen Hinton /	rpe. Print) Aunt	19b. Mailin 4617	g Address (Street W.Fore	and Number or I st Parl	Rural Route Number	er, City or Town, State, Altimore	Zip Code) Md 21207
altimore, mit. Pages 1 er	ant: If item ury or othe		20a. Method of Disposition  15☐ Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)	lamaval from Ctata	emetery, cren	sition (Name of natory or other place Cemete:	ry 4,	Date /1/06	20c. Location - City of Lansdow	
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* /N	/sician ledical aminer		23a. Pay1. Enter the disease, or complessock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death re cause on each line.  a. <b>HULTIPLE</b> Due to (or as a consequence)	INSHO					Approximate Interval Between Onset and Death
death certificate be executed	physicien and the burial-transit	dicai Examiner	S uentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						
hat the death certific	y the ettending pl ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
	been signed by the e should be detached f	ρ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
로 <sup>독</sup>	s certificate has bee lirector, page 2 sho	Completed				····		24a. Was autop perfor	sy prior to rmed? death?	utopsy findings available completion of cause of s 2 No
ician	certific rector,	Be	25. Was case referred to medical examiner?	ospital:		3D DOA Oth		eath (Check only o		
ž į	a this	5	1 □XYes 2 □ No  27. Manner of Death	1 🖾 Inpatient 2 🗍 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3 DOA 28c, Injun	4 🗆 14015111g		lence 6 Other (Spe	ecify)
or Attending Physician:	rector: After by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	3/22/06	10:37	<b>Y</b> M 1□	k? Yes 2 <b>⊈</b> No	SUBTE	ct was	SHOT
itel or A	rel Direc led in by		4 determined	28e. Place of Injury - At ho building, etc. (Specify	HUK Stre	et, factory, office		City or Tou	Street and Number or R n, State) FD LEY RD, DA	ural Route Number,
To the Hospitel	To the Funerel Dire completely filled in b	edicai	29a. Certifier (Check only one)  1 ☐ Certifying Phys 2 ☒ Medical Examir	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occ	ce, and due to the courred at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the	Tot	W	29b. Signature and title of certifier	<u> </u>		29c. License			29d. Date signed (Mon March 25.	
`	5		30. Name and address of person who co	310, MD			n Street	Baltim	ore, Maryla	
	Sta	te	MAR 2 9 2006	32. Registrars Signat	wast B					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2 Date of Death March Z?40PM Edna May Lowry Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death mine Washington Madical (Dr.) からん 5 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 12/03/1922 7. Age (In yrs. last birthday, Months Hours Days 1 ☐ M 2 🛣 F Yrs. 213-18-0523 83 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8446 Bussenius Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert John Baker Edith Mary Hand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Adams/Daughter 7853 June Drive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem 03/31/06 Crownsville, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Euneral Service Licenses 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 15 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 **18** No 1 ☐ Yes

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

28a-1 show

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"natural",

and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar trau once.

the Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

68760 99

Box

P.O.

Division of Vital Records,

or Attending Physician: The law requires that the death certificate

after death

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Medical

Examiner must be notified at

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Examiner attending physician by Physician/Medical Completed peen Be ( 2 this Certification: After

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

and manner stated

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

3 Suicide

29a. Certifier

5 Pending investigation

Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) title)of\_certific 29b. Signature as

29c. License number 480

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Um

Hospital:

31. Date filed (Month, Day, Year) State 9-2006 Registrar

32 Registrar's Signature

			State of Maryland / Department of Health and  1 - State Registrer  Certificate of Death	Mental Hy	giene	6 1	19576
	2 3 11		Decedent's Name (First, Middle, Last)	2. Date of De	eath		3. Time of Death
_	Physic /Med		John W. Lozanski	Month 03	Day 2	Year 2006	20:37 PM
	Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County		-20.0/ 211
		No.	Upper Chesapeake Medical Center Bel Air, Maryla		Harf		
	Funera		5. Social Security Number 6. Sex 1 X M 2 F 7. Age (In yrs. last birthday) 1 Yrs. Months Days Hours Min.	(Month, D	ay, Year)	Coun	
	Directo		Usual Residence of Decedent	09/02/	1922	Mar	yland
	yland		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mar Mar	tor	MD Baltimore Kingsville				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	Whal Coun	itry?
0	ath w				U.S.A		
2	er de:	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Survey of Control	Specify Yes or No no Rican, etc.)		ce - Americ ick, White,	
7	36 rs afte	by F	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩ II		Specif	<sup>fy:</sup> Whi	to
2037	P hou		YAVY II		16b. Kind of B		
$\widetilde{\omega}$	215 hin 72 nn 'nu	piet	(Specify only highest grade completed)  (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	orking			
2	d 212 filed with Hygiene. other ther	Completed	12 Self-Employed		Home I	mprov	rement
-0	Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. I dother then "naturat", or Items 23a or 28a-f show event, the Madical Exempter must be notified at	e e	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle	a, Maiden Sumar	71 <del>0</del> )	
	aryland 21215-0036 should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Madical Exempter must be notified at	ို		a Braun			
9	Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. 77 is marked other then "natural", or traumatic event, the Madical Extra	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R			111	
9	e, M 1 and 2 Health 1 em 27		Olive J. Lozanski (wife) 6611 Mount Vista Road  20a. Method of Disposition 20b. Place of Disposition (Name of	Dale	20c. Location	-	
3/30/ce/E	Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menit Important: if them 27 is marked eny Injury or other traumatic ence.		1 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	25/2006			
0	Iltir nit. P artme ortan injur		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility E.				
(1)	Balti permit. Departr Importa		E. A. Lassalw 11750 Belair Road	- Kings	ville. M	uai n Marvla	and 21087
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Mocaradial Inforction	n -			Onset and Death
•	/Medica		resulting in death)  Due to (or as a consequence of):	>			
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#	68 tificat tig phy as the	edi				1/	
2	I Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE:  23b. Was decedent pregnant  1			ate of delive	•
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Z	P.O.	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did	tohacco use con	tribute to th	ne cause of death?
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1	of Vital Re Physician: The la r this certificate hai	0 8	examiner?		idence 6 □Oth	her (Specif	v)
X	vision of Vita Attending Physician: r death. ector: After this certification the funeral director.	Ë	27. Manner of Death 28a. Date of fnjury 28b. Time of 28c. Injury at		how injury occur		
9	r Attending Per death.	atio	2 Accident investigation M 1 Yes 2 No				
3	Division of or attending Phy after death. Director: After this in by the tuneral d	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numi wn, State)	ber or Rura	l Route Number,
ozansKi,	Hospital of thours at Funeral Dittel (1997)					•	
7	Hosi 24 ho Fune etely f	Medical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plac (Check only one)				
_	Division  To the Hospital or Attention within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier 29c. License number		29d. Date signe	-	
			D 0053.	120	03/	23/	2006
	2011		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Beloi:	mp	2100	cct	
	S Regis	tate trar	31. Date filed (Month, Day, Year)  MAR 2 9 2006  Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Minnie L. Lawrence March 2006 9:20P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care @ Spa Creek Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov 12 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💯 F 214-76-8426 93 Yrs. 1912 Georgia Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural, or itama 23a or 28a-f ahov the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1XXes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 President St. Apt Al 21403 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐Xvo **Black** Specify ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 5th permit. Peges 1 and 2 should be filed v Department of Heelth and Mental Hygie Important: If itam 27 is marked other ti any injury or other traumatic avant. Its once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unobtainable Fannie Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 Fannie Davis(Daughter) 1012 President St. Apt Al Annapolis, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Best garage of Disposition) (Name of Disposition) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3-10-06 Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Jarry H. Reese MOO 483 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and s the burial-transit o the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for u Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 🕅 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: A hours after dea... 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 20a. Cartilia 1 Discriffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

**ORIGINAL** 

Conio Lee 06-02077 MUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item# 23a, 27, pen/f., 854, 4/12/06 TT State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month TONIO LEE 2006 March 2315 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 4200 Colborne Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months tX M 2□F Director 220-06-9262 21 1-31-1985 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits the Medical Examiner must be notified at MD. N/A BALTIMORE 1 XYes 2 No Directo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23a or 4200 COLBORNE RD. 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: lteme: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian. Black, White, etc. hours after 1K Never Married 2 ☐ Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced "neturel", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) then. Elementary/Secondary (0-12) College (1-4or 5+) -10--0-LABORER CAR WASH other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy importent: If Item 27 is marked other eny injury or other transment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTONIO LEE MARCHELLE GOODE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELESHIEA GOODE (AUNT) 900 N. WOODINGTON RD. BALTIMORE, MARYLAND 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State MT. ZION CEMETERY 3-31-2006 BALTIMORE, MARYLAND 21. Signature de eral Service Licensee JONATHAN D. HIBNERName and Address of FacilityREDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 I be not the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seizure disorder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.0. the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ cate has been si, page 2 should t 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death2

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner Other: 4  $\square$  Nursing Home 5  $\square$  Residence & Other (Specify) Scene ပ XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Division or Attending 1 X Natural 5 Pending after death.

Director: All
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23t Cartillat Medical (Check only 29b. Sigflature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME March, 25, 2006 aryune o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person \* YAMUSOUTS 111 Penn Street Baltimore, Maryland 21201 KUREU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician Montherch Day 7, 2006 5:06P /Medical 4c. County of Death Baltimore Examiner Months Days Hours Min. 8. Date of Birth (Month, Day, 1) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 220-24-85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? items 23a or 5. Funeral Was Decedent Ever in U.S. Armed Forces? 1 Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1□ Yes 2√No If Yes, Give Year or Dates: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be file.
Department of Health and Mental Hys, important: if item 27 is marked other any injury or other treasment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD. ORRAINE SIONE 3ALTO, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Bunal 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOGENIC SHOCK Physician /Medical Due to (or as a consequence of):
MYDCARDIAL INFARCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit CORONARY ARTERY DISEASE Due to (or as a consequence of): Records, P.O. Box 68760, VENTRICULAR ARRHYTHMIA Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RESPIRATORY FAILURE 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE autopsy 1 Tes of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tes 2 ER/Outpatient 3 DOA this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; within 24 hours after death. To the Funerel Director: After Division To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31826 3-28-0C w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM M.D. 7601 OSLER DRIVE TOWSON, MD. 21204

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31. Date filed (Month, Day, Year) MAR 2 9

32. gistrar's Signature

2006

State Registrar

	1	State of Maryland / Department of Health and Certificate of Death	Mental Hygien	. U U U	09580
Physicia	an	1. Decedent's Name (First, Middle, Last) Rachel Magno	2. Date of Death Month D Manuel 2	Day T4 2000	3. Time of Death
/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Howard County General Hospital  4b. City, Town, or Location of Deat Column		tc. County of Death	ard.
Funeral Director		5. Social Security Number 6. Sex 1		ir) Coi	nplace (State or Foreign untry) V Jersey
Maryland f ehow	tor	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the 3a or 28e	Il Director	10e. Street and Number 4998 Dorsey Hall Drive Unit 8-4 21042	10g. (	Citizen of What Co	untry?
id yidiid ZIZIS-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural," or Items 23a or 28e-1 show aumatic event, the Madical Examinational be collified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1	Specify Yes or No- tto Rican, etc.)	14. Race - Amer Black, White Specify:	
ad within 72 hours afi giene. er then "natural, or the Medical Exemi	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work interest) (ifte. DO NOT use retired)  Homemaker	orking	Kind of Business/	
- a - 0 S	To Be C	17. I attiet 3 I fattie (1 1/3t, 1/1/dolo, 243t)	me (First, Middle, Maid nine DiGel		
MICE Should be fill alth and Mental H; so I e marked other traumatic events		19a. Informant's Name/Relationship (Type, Print) Mary Jo Oates/Daughter  19b. Mailing Address (Street and Number or R 4998 Dorsey Hall I	Or. Unit	y or Town, State, 2 8-4 E1. Md. Location - City or	licott Cit
Dallilliore, Malylal plat permit. Pages 1 and 2 should by Deperment of Health and Menta important: If Item 27 1e marked eny injury or other traumatic enges.		1 Denation 1 Conception 1 Denation 1 Denatio	31/00 M	ontclai	r,N.J.
permit. Depertiment on inj		21. Signature of Funeral Service Lichnson  21. Signature of Funeral Service Lichnson  22. Signature of Funeral Service Lichnson  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		SERVIC	E, P.A. Ig, Md20910
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Septu Shorely  Due to (or as a consequence of):	och'		Interval Between Onset and Death
icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Mataliaalia audion of the consequence of the conseq	is searce		,
death certific	by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		23d. Date of del	ivery Day Year
ures thet the signed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc		o the cause of death?
OI VICAL DECOLUS, F.O. Physician: The law requires that the ribis certificate has been signed by the rial director, page 2 should be detached.	Completed		24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
OI VITAL I Physician: Th rihis certificete rai director, pag	8	examiner?	eath (Check only оле) Home 5 Пesidence	e 6 ∏Other (Soe	cify)
SION tending leath. tor: Afte the fune	ertification; To	27. Manner of Death    1 Natural   5   Pending   28a. Date of Injury   28b. Time of Injury   Work?   1   Yes 2   No	28d. Describe how in 28f. Location (Stree City or Town, S	njury occurred t and Number or R	
DIVI To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	ledical Cert	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	ce, and due to the caus- curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier  29c. License number  29c. License number  D 50870  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Suran Ando 505 Signal Iself Lawl Claud	294	Date signed (Mon	th Day Year)
		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sulan Ando 5005 Signal Sell land Claud	lisulle n	10 210	529
St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature			

		•	For State Registrar			ertificate of	Death	ental Hygie Reg.		00001
	P (F		1. Decedent's Name (First, Middle, L	.ast)				2. Date of Death Month	Day Voor	3. Time of Death
	Physici /Medic		Graham Keefe Mo	cBurney				March 25	Day 2006 Year	5:00 A M
9	Examin	_	4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
Foy.			300 Torner Road			Essex	Milledge Od Hee		Baltimor	
	Funeral			TOTAL OFF	o (In yrs. last birthda OC Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo Oct. 5, 19	9. Birth	nplace (State or Foreign untry)
-80	Director		213-03-5819 Usual Residence of Decedent		86 Yrs.			OCE. 5, 1	919 Mary	vland
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar Mar	ţċ	Maryland Baltimon	re	Essex					1 ☐ Yes 2XXXIo
	or 28	lre(	10e. Street and Number			10f. Zip Code		10g	Citizen of What Co	untry?
	death with the Maryland me 23a or 28a-f show frount be notified at	ral	300 Torner Road			21221			U.S.A.	
	2 hours after death with the Marylar aturel', or iteme 23a or 28a-f show cel Examirer mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 10	<ol> <li>Was Decedent of H If Yes, specify Cub.</li> </ol>	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
30	hours after ture!, or ite	by F	1 Never Married 2 Married  3XXVidowed 4 Divorced	I 15 Tves 2 □ N If Yes, Give Year or Dates:	□ 1941– 1945	1 ☐ Yes 2 CXNo	Specify:		Specify:	nite
212-0036	72 hours nature!,	ed	15. Decedent's	Education		cedent's Usual Occup	nation during most of workii	16	b. Kind of Business/l	
2 2	within 72 ene. then "na	ple	(Specify only highest g	grade completed) College (1-4or 5	life	ve kind of work done . DO NOT use retire	during most of workii d)			
N	d wit	Completed	10		Fire	fighter			altimore (	lity
/land	be filed tat Hygi d other event,	Be (	17. Father's Name (First, Middle, Las				18. Mother's Name		iden Sumame)	
∑ã	Ment Ment arke	၉	Graham Alfred Mcl				Irene O'			
Mar	2 sh and is m		19a. Informant's Name/Relationship				and Number or Rura		_	·
	s 1 and f Health item 27 other tr		Patrick McBurney  20a. Method of Disposition	(SOII)		position (Name of	Avenue, Ba		c. Location - City or	
פֿר	permit. Pages 1 Department of H Important: if ite any injury or ot		M⊠Burial 2 ☐ Cremation 3		cemetery, c	rematory or other pla	ce)	1.7		, Maryland
galtimore,	it. P.		4 Donation 5 ☐ Other (Spec							
ğ	Dep limp	0	Dellord	mydy (		Bi 1407 Old	ruzdzinski Fastern A	Funeral venue E	Home, P.A ssex. Mary	land 21221
ď.	- 46.7	1	23a. Part1. Enter the disease, of co shock, or heart failure. List on	inplication that caused	the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		HYPOTE					Onset and Death
1	/Medical		resulting in death)	a	a consequence of):	<u> </u>				
	Examiner		Sequentially list conditions,	bBL	ADDER	CANC	CER			Years
1	p tis	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of).	784	276	TOTAL PART		
$\sqrt{}$	and I-tran	Examln	that initiated events resulting in death) Last	c. Due to (or as	a consequence o :	ARTE	RY D	ISEAS	ž	years,
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-	ficate physics the	edical			•	1000				
Ω Q	death certifi e attending I od for use as	M								
٥	deatl e atte d for		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3∏Estania prespana			23d. Date of deli	very
BOX 6		sicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	
O. Box 6	at the de by the satached	Physicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	5 Other (specify)	•		Month	very Day Year
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Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions  COLON POL  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigat 3   Suicide 6   Could not 4   Homicide   Could not determine (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatie  28a. Date of Inju (Month, Da  titon t be ed  Physicien: To the best teminer: On the basis o and manner sta	2 Fetal death time of death (Item 23a) (Typical	e underlying cause gruent 3 DOA Ct Wood DOA Street, factory, office Bath occurred at the trainvestigation, in my control of the property of th	26. Place of Deather:  26. Place of Deather: 4 \( \triangle \) Nursing Horry at (k?) IYes 2 \( \triangle \) No  me, date and place, appinion, death occurry se number  4/4-9-6	1 PYes  24a. Was an autopsy performe 1 Yes 25 Am (Check only one)  me 5 Amesidence 28d. Describe how 28f. Location (Stree City or Town, and due to the cau ed at the time, date	Month  2 No 3 Pro  24b. Were au prior to a death? 1 Yes  26 G Other (Specinjury occurred)  28 and Number or Rustate)  3 2 7 2	Day Year  The cause of death?  Dobably 4 Unknown  Topsy findings available completion of cause of 2 No  City)  Trail Route Number,  stated, to the cause(s)

DHMH 17 Rev 1/2001

		1	For State Registrar	State of M	aryland / De		Health and M		211116	09582	)
	Physicia	ın	1. Decedent's Name (First, Middle, L Marion Scoville					2. Date of Death Month March 19	Day Year	3. Time of Death	м
	/Medic Examin		4a. Fecility Name (If not institution, g Harford Memorial	ive street and number)			or Location of Death de Grace		4c. County of Death Harford		
10	Funeral Director		5. Social Security Number 6. 082-20-2342	Sex 1 □ M 2 □ X F	ge (In yrs. last birtho 79 Yrs	Months Days	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Ye 07/06/19	ar) 9. Birth Cou 26 New	place (State or Foreig ntry) YOAR	gn
0315	faryland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o					10d. Inside City Limit	
19/06	death with the Maryland me 23a or 28a-f ehow rmiet be notified at	Director	MD Harfor		παυπε	de Grace 101. Zip Code 21078			Citizen of What Cou	ntry?	
W	rs after death	by Funeral	612 Alliance Str.  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces	Ever in U.S. ? No		f Hispanic Origin? (Spe uban, Mexican, Puerto I		14. Race - Ameri Black, White	, etc.	
Dr. Sly Maryland 21215-0036	within 72 hours ane. than "natural", te Medical Exa	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	ecedent's Usual Occ Give kind of work don ife. DO NOT use retii CACHET	upation ne during most of workii red)	ng	Elementary		
Dr. F	12 should be filted within h and Mental Hygiene. 7 ie marked other than "fraumatic event, tra Me	To Be Co	17. Father's Name (First, Middle, La Clarence Scovill				Kathari	(First, Middle, Mai ne Terry	den Sumame)		
Saltimore, Mary	alta alt		19a. Informant's Name/Relationship  Alan Miller - Sor  20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe  21. Signature of Funeral Service Lice	L □Removal from State	20b. Place of Commetery.  Angel 1	60 Nelson Disposition (Name of crematory or other p	03/22	sonbwrg, <sup>200</sup> /06 Ha	VA 22801 Location - City or T LVRE de GR	own, State	
B	Physician	4	23a Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a. MYM	d the death. Do no line.	t enter the mode of d	dress of Facility Smith Fune Shington, H tying, such as cardiac o	avre de C or respiratory arrest	Grace, MD	21078 Approximate Interval Between Onset and Death	
8760, <	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicien and prompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHICAN Due to (or a	s a consequence of	CANCER-	amonmy of	NKEMME			
.O. Box 68	the death certificate y the attending phys iched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 ∐ Fetal death at time of death	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of deli Month	very Day Year	
S, P	juires that n signed b		Part II. Other significant condition	s contributing to death	but not resulting in t	the underlying cause	given in Part I.		co use contribute to	the cause of death?	wn
Marian for of Vital Record	: The law requires that the cete has been signed by the page 2 should be detache	Completed by	Hypenters 1014	17				24a. Was an autopsy performe 1 ☐ Yes 2	d2 prior to death?	topsy findings availab completion of cause of 2 No	ole of
MC MC	nding Phyeicien: ath. r: After this certific e funeral director,	n: To Be	25. Was e referre medical examiner? 1 Yes 2 No 27. Mann of Death	Hospital: 1 Inpat		me of 28c, Ir	Other: 4 Nursing Ho	h (Check only one) me 5 ☐ Resident 28d. Describe how	e 6 Other (Specinjury occurred	ufy)	
Miller Division	i or Attendin after death. Director: Afi I in by the fur	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 6 Could no determin	tion 28e. Place of I			□Yes 2□No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
	ne Hospitai 24 hours a ne Funerai l	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner	of examination and	death occurred at the /or investigation, in m	time, date and place, y opinion, death occur	red at the time, date	and place, and due	to the cause(s)	
•	To the within 2 To the comple	M	29b. Signature and title of certifier  Hisupsium	m.n.		(	ense number D4641	290	3 119 (0 6	ı, Day, Year)	
_	12		30. Name and address of person w	319		Type, Print)  WMICH	for Mo	6 mp	4078		Ī
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) WAR 2 g	2006 32. Tagis	strar's Signature	partie					

06 <b>-</b> 01 John	.914 A. McQu	ıad	e For II	Plea An inpendit	ase T end	ype or item State	<b>Prir</b> <b>20</b> b	nt in l per arylar	Black I	ndeli 354 gartm	<b>bie ink</b> 4-4-06 ent of	Ens Vt Tealth	ure A	II Copie Iental H	s Are	<b>Leg</b> i e	ible.	
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	Physic	ian	1. Decedent's Nam	e (First, Midd	lle, Last)									2. Date of D		ay	Year	3. Time of Death
	/Medi			Quade										March	18,	2006	5	0810 A. M
	Exami	ner	4a. Facility Name (			treet and no	umber)				City, Town, o		n of Death		4	c. County	of Death	1
10	Francis		1708 Li		6. Sex		7. Ag	e (In vrs.	last birthda	_	altimender 1 Year		er 24 Hrs.	8. Date of E	lirth		9 Birth	place (State or Foreign
3	Funeral Director		219-92-4			M 2□F		42	Yrs.	Mon	ths Days	Hours	Min.	8. Date of E (Month, L 07/28	7196	") 3 1	MD Con	intry)
	P .		Usual Residence o	1				1.0										
	anyla shov	7	10a. State	10b. County		a · .			ty, Town or									10d. Inside City Limits 1♣Yes 2 □ No
	the M	ecto	MD 10e. Street and Nu		Lmore	e City		Bal	Ltimor		. Zip Code				100.0	itizen of	MI 0	
	with Sa or		1708 Ligh	70-50	et.						1230					ted		
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. Item 271s marked other than "natural; or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified.	Funeral Director	11. Marital Status			2. Was Dec		Ever in U	J.S. 13			Hispanic C	origin? (Sp	ecify Yes or N Rican, etc.)				ican Indian,
9	after or ite	Ē	1 Never Marr	ried 2 Ma	rried	Armed F	2 🗆 1	No			specify Cub			Rican, etc.)			ck, White	, etc.
93	hours after lural, or ite	d b	3 Widowed	4 Divorce	d	If Yes, G Year or I	Dates:	1981-	1984	1 🗆 1 6	is ZZNO	Specify	у:			Specif	y:	
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7	within ene. than	声	Elementary/Seco	ondary (0-12)		College	(1-4or 5	5+)	Hand			a)			COn	ISCIU	ICCIO	11
9	filled Hygi other	0	17. Father's Name	(First, Middle	Last)				1.	2		18. Moti	her's Name	e (First, Midd	le, Maide	n Suman	ne)	
<u>a</u>	lid be lental ked c	To B	Richard	Alan Mo	Quad	е						Unkr	nown	Unknow	n			
Maryland 21215-0036	shou and N	-	19a. Informant's N			e, Print)			19b. Ma	iling Add	ress (Street	and Numi	ber or Run	al Route Num	ber, City	or Town,	State, Zi	ip Code)
Σ	is 1 and 2 should be filed within by Health and Mental Hygiene, tem 27 is marked other than other traumatic event, the Mental Hygiene, the Mental Hygiene is a should be should		Amy Pisto	orio/Si	ster				_					rkvill	e, M	D 21	234	
Baltimore,	of He		20a. Method of Dis 1 Burial 2		3 □Re	emoval from	State		Place of Disponentary, cr				4-3-	06 ba 0				own, State
Ë	permit. Pages Department of I Important: if it eny injury or of	5 9	4 Donation	5 Other (S	Specify)			Garı	rison F				٦	9-			M1.	lls, MD
Bal	Depar Depar Impor eny in		21. Signature of Fu	Ineral Service	License	θ	Į.	۸, ۱	000	22. Nam C <b>rem</b> a	e and Addre	ss of Faci and Fu	ility uneral	Alter	nativ	res		yland 21286
<b>9</b> 0,	Physician /Medical Examiner  wrial-transit	il Examiner	23a. Part1. Efter to shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list codification and to incause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on on of the control of the c	a. b.	Mixed Due to	Dru (or as	ig (Co a consec a consec	pcaine a quence of):									Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 [ 9 □ Unknown	months? ☐ No	d.		birth nant at	of pregna 2   Feta time of o	il death 3		ic pregnancy (specify)	y		-7		23d. Dai Mo	te of deliv	ery Day Year
Division of Vital Records, P	quires that the de n signed by the a uld be detached f	by	Part II. Other signif	ficant conditi	ons cont	ributing to d	death be	ut not res	ulting in the	underlyir	ng cause giv	ren in Part	1.		tobacco Yes 2			the cause of death?
ဝွ	aw requir s been si 2 should I	Completed												24a. Wa	s an	24b. \	Were auto	opsy findings available
æ	The lav	E		<del> </del>										aute per 1 X Yes	opsy formed?		death?	ompletion of cause of 2 No
ita	iician: Th certificete rector, pag	Bec	25. Was case refer	red to medica	1						20000	26. Plac	e of Death	(Check only		,	14100	2 140
<u>&gt;</u>	\$ 00 75	To	examiner? 1X Yes 2	No	Ho				ER/Outpation	ent 3	DOA Oth	ier: 4 🗆 N	lursing Ho	me 5 Res	sidence	6 √ Oth	er (Speci	( scene
Ē	ding Phy h. After thi funeral o		27. Manner of Deat 1 ☐Natural	h 5 ⊡ Pendia	ng	28a. Date (Mor	of Injur		28b. Time Injury		28c. Injur Wor			28d. Describe	how inju	ry occurr	ed	
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Ξ	or At after of Dirac in by	il.	4 Homicide	detem	nined				ome, farm, s	street, fac	ctory, office			City or To	own, Stati	e) 1709	eror <i>Run</i> 3 Ligh	al Route Number, it Street
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	the Hospital hin 24 hours of the Funeral I npletely filled	Medical	(Check only one)	Medical	Examin	er: On the b	oasis of	examina	ition and/or i	investiga	tion, in my o	pinion, de	ath occurr	ed at the time	, date an	d place, a	and due t	stated. o the cause(s)
	To the Hospital or Attend within 24 hours after deatl To the Funeral Diractor: completely filled in by the	₩ We	29b. Signature and	title of certific	r /		7	10			29c. Licens	e number			29d. Da	ate signed	d (Month,	Day, Year)
	. 2. 0			NI	6	V	V	V(			0.0	C.M.E			Mar	ch 1	8, 2	006
			30. Name and addr	ess of person	who con	pleted calu	se of de	eath (Iten	п 23а) (Туре	e, Print)	L11 P∈	enn S	treet	, Balt	imor	e Ma	ryla	nd 21201
	Sta	te	31. Date filed (Mon	th, Day, Year)	)	32. F	Registra	ar's Signa		ate .								
	Registr	ar		MAR 2	9 200	16 1	3.0	A.F. B	M.	done	E							

	1	For State Registrar	State of	Maryla	-	artmen rtificat			and Me	ental Hyg	iene	06	09584
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last, Robert H. Miller 4a. Facility Name (If not institution, give 6505 Stoneham Roa	street and num	nber)		1	Town, or	Location o		2. Date of Dea Month March	24, 20 4c. Cou	Year 006 unty of Death	
Funeral Director		5. Social Security Number 6. Sec. 552–12–7036		7. Age (In yrs 81	. last birthday, Yrs.	1		If Under 2 Hours	Min.	8. Date of Birth (Month, Day ovenber	Year)	9. Birth	place (State or Foreign intry) ifornia
e Maryland		Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	ery	10c. C	Bethes								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with the 23a or 28		10e. Street and Number 6505 Stoneham Road					2081				Uni	of What Cou ted St	ates
1215-0036 within 72 hours after death with the Maryland and. and. he "hatural", or items 23a or 28a-f show he Madical Examiner must be notified at annihiland at the Madical Control of the Control of th	on a constant	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	If Yes Give	ces? 2 □ No WO	rld	Was Deced If Yes, spec			gin? (Spec , Puerto P	cify Yes or No- lican, etc.)		Race - Ameri Black, White ecify: Wh:	, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural," or tiems 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.  To Re Completed by Funeral Director	and in	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1- 4	-4or 5+)	(Give	dent's Usua kind of wo DO NOT us 1. Arc	rk done d se retired	luring most )	of workin	g		f Business/Ir	
Maryland 2 d 2 should be filed the and Mental Hyg the and Mental Hyg traumatic event,		17. Father's Name (First, Middle, Last) Herman Miller						Do	ris I	(First, Middle, I England			
re, Mar 1 and 2 sh Health and tem 27 is m	-	19a. Informant's Name/Relationship (Ty David Miller/Son  20a. Method of Disposition	rpe, Print)	20b.		Kings	Rid	ge Roa	ad, A	Poute Number	altim		D 21234
Baltimore, sernit. Pages 1 a Department of Her mportant: if item ny injury or othe page.	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Services Licens		State I	te of He	aven Co	emete:	ry s of Facility	arch 2006 Robe	ért A.	Silve:	r Sprii rev Fu	ng, Maryland neral Home/
Ba permi Depa impo	1	23a. Part1. Enter the disease, or compl shock, or heert failure. List only or	ications that ca	used the dea	433 B	ethes	da,	Maryl.	and 2	20814-3	501	Wisco	nsin Avenue Approximate Interval Between
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of Vital Records, P.O. Box 68760,  Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit. To Be Completed by Physician/Medical Examir		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		rth 2∏Fei ant at time of	al death 3	Ectopic pr Other (sp					23d.	Date of deliv Month	very Day Year
w requires that been signed to should be deticated by Pleased by P		Part II. Other significant conditions cor	ntributing to de	ath but not re	sulting in the u	inderlying c	ause give	en in Part I.					the cause of death?
Vital Records, sicien: The law requires t certificate has been signe rector, page 2 should be to Be Completed by										24a. Was a autops perform	ned?	lb. Were auto prior to co death? 1 🗆 Yes	opsy findings available ompletion of cause of 2 No
Jing After fune		25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		npatient 2[ f Injury n, Day Year)	ER/Outpatie 28b. Time o fnjury		8c. Injury Work	or: 4□ Nur	rsing Hom	Check only on e 5 ⊠ Reside 3d. Describe ho	ence 6 🗆		(fy)
Division of the or Attending Program or Attending Program of the transmission of the t		3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At I	nome, farm, st	reet, factory	, office		28	Bf. Location (St City or Town	reet and Nu n, State)	ımber or Rur	al Route Number,
DIVISIC To the Hospital or Attentivition 24 hours after dearn to the Funeral Director: completely filled in by the Medical Certifical		29a. Certifier 1 Gertifying Physical Examinates (Check only one) 2 Medical Examinates (Check only one)	sician: To the ner: On the ba and mann	sis of examin	owledge, deat ation and/or in	vestigation	in my op	oinion, deat	d place, ar h occurre	d at the time, d	ate and plac	ce, and due t	to the cause(s)
T W T O D		29b. Signature and title dicertifier	<u> </u>		00a) 77	1	. License					27, 2	
١٧		30. Name and address of person who co Anushiravan Dadga: 31. Date filed (Month, Day, Year)	r, M.D.	9715	Medica	1 Cen		Drive	, #20	)1, Rocl	kville	e, MD	20850
State Registrar		MAR 2 9 2	006	ryistrar's Sign	AS A	book	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30 Month Year **Physician** IMES 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN BALTINORE Future Care Old Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 15, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 261-09-4997 88 Vrs 1917 South Carolina Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Items 23a or 28s-fehrm 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Counts or items 23s or 28s-f shown their wat be notified at 1√2 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4800 Yellow Wood Avenue #315 14. Race - American Indian, Black, White, etc. 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black The Madical Exar-څ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) merchant marine military 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Benjamin McBride Classie Johnson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth McCormick/sister 4800 Gilray Drive Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation \_5 ☐ Qther (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approximat 21. Signature of Funeral S rvice Licensee Ron 1 d, S, Wade Wade, Director mon 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL CELL CANCER Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hyar) that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ate has been signed by the a page 2 should be detached: 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 ™thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the **Diractor**: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 \ Homicide within 24 hours after To the Funeral Dirac t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. S. NAS. M. O 043462 MARCH 24 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K - S - R A > - T -OLD COURT RANDALLSTOWN MO 51123 ROAD # 108 5400 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 0

State of Maryland / Department of Health and Mental Hygiene 09586 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 24 2006 Physician 8:45 A Rollin Edward Nelson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner Baltimore Freeland 21232 Millers Mill Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. November 4 1938 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Baltimore, Maryland Yrs 67 212 38 8173 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County rthan "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Fræland Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21053 USA 21232 Millers Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Konea 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. College (1-4or 5+)
VA Elementary/Secondary (0-12) Superintendent Baltimore County Highways 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental h Mary Anna Riley George Edward Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ant: if Item 27 is 1910 Searles Road Dundalk, Maryland 21222 Rebecca L. Nelson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or once. Lake View Memorial. Park March 30 2006 Sykosville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Road Lassahn Funeral Home Inc Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mitastatic LUNG CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical use as 1 attending p 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death signed by the at d be detached fo 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physicien: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 11X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02/022 3-24-06 mileyla Merzen 16×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Xtor MI) 21236 n. Ken Albuski 7602BERMIN 31. Date filed (Month, Day, Year). 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM/5, perFH, G861, 11, 3/06, WS

State of Maryland / Department of Health and Mental Hygiene 09587 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** 26 2006 1:15a Hiroshi Harold Nishi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. S3596022V N9281 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min DOM 2016 12 8560 Vrs Director California 06-23-1922 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts Worle in than "natural", or itame 23a or 28a-f ehov the Modical Examinar must be notified at 1 ☐ Yes 2X No MD Silver Spring Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3128 Gracefield Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐XMarried Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2KNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Health Biochemist filed 27 le marked other r traumatic event, il 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Unavailable ss 1 and 2 should be of Health and Mental Itam 27 le marked Unavailable ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11420 Beechgrove Ln Potomac Md. 20854 Alan Nishi/son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
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any injury or ott 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State Chesapeake Crematory 03-28-2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Rapp Funeral & Cremation Service
933 Gist Av Silver Spring MD 20910 21. Signature of Funeral Service M00382 23a. Part1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, beauty to in its orients cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner The law requires that the death certificate be executed nding physicien and use as the burial-transit Candida and staph Sepsis that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination proformy stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ş 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

Purnima Joshi 1500 Forest Glen Rd Silver Spring MD 20910

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CPM 06-02098 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item # 23a, 27, per/ME, C854, 4/10/06 TT State of Maryland? Department of Health and Mental Hygiene Carolyn Peterson 1 - For State Registrar Certificate of Death Reg. No.-2 Date of Death Decedent's Name (First, Middle, Last) Day Yea Physician terson 25, 2006 March 20:03 /Medical 4c. County of Dpa 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bon Secours Hospital Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 212-88-3395 7. Age (In yrs. Jast birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ■ M 22%F 3 ARelland Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturer", or items 23a or 28a-f ehov empirigury or other traumatic event, if a Medical Exaction of the notified at once. SAH'more 1XYes 2□No d Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 92 an Vale 216 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Indu (Give kind of work done during most of working if a DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tome makes 17. Father's Name (First, Middle, Mother's Name (First, Middle, Maiden Sumame Be 60 ဥ Mailing Address\_(Street and Number 21225 Cunice 20c. Location City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Zion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomegaly /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 26, 2006 O.C.M.E. pleted cause of death (Item 23a) (Type, Print) COREU ARGIS PUTTS 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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9 2006

gistrar's Signature

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36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: WH	ITE
2-003	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene death Hygiene of the charten and the Madical Examinar must be notified at event, the Madical Examinar must be notified at		15. Decedent's Education (Specify only highest grade	ation	16a. Dece	dent's Usual Occupat	ion	16	b. Kind of Business/	
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)		9	<b>GT 0-117</b>	
121	filed w Hygier other tl	Co	17. Father's Name (First, Middle, Last)		SE	AMSTRESS		e (First, Middle, Ma	CLOTHII	NG
auc		To Be	JOSEPH DANION	J			JULIE	KEKEL		
Maryland	s 1 and 2 should be I Health and Menta Item 27 le marked other traumatic ev	۲	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street ar	nd Number or Run	al Route Number, (	City or Town, State, 2	Zip Code) 21042
	and 2 ealth: m 27 I		OREST POLISZCZUF						LICOTT (	CITY, MD.
altimore,	60		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	-	natory`or other place	)		c. Location - City or	
<u>=</u>	permit. Page Depertment of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	\$1					BALTIMO	
Ba	Depe Impo			2	1	ILLY & Z 901 EAST	EILER ERN AVI	INC. FUN ENUE BAT	NERAL HON	ME MD. 21231
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	.4/2/	heime					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con						
		er	Sequentially list conditions, if any, leading to immediate	Dua to (or page con	e) fen 5 sequence of):	1 1				
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Dia	betes !	Wellits,	type 1	/		
Ö,	e exec ien ar urial-tı		that initiated events c. resulting in death) Last	Due to (or as a con						
58760,	licate be executed physicien and s the burial-transit	edical	d.							
9 ×			IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre	egnancy				23d. Date of del	ivery
Box	that the death cert ed by the attendin detached for use	Physician/M	in the past 12 months?  1  Yes 2  No	1 Live birth 2 ☐ F 4 Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
P. O.	at the by th	hys	9 Dunknown	9□ Unknown						
s,	w requires that been signed I should be det	ρ	Part II. Other significant conditions cont	ributing to death but not		nderlying cause giver	n in Part I.		cco use contribute to	the cause of death?
Ö	requi	eted	Nelson	10-10-	7(10					
Rec	helaw shasi ge 2 s	Completed	Ostcool	210813				24a. Was an autopsy performe	prior to death?	completion of cause of
ta	en: T tificate tor. pa	0	25. Was case referred to medical	y) o k			26. Place of Deat	1 Yes 2 h (Check only one)	1 ☐ Yes	2□ No
Division of Vital Records,	nysici nis cer direct	To B	examiner?	ospital: 1   Inpatient	2 ER/Outpatier	Otho	-		ce 6 ☐Other (Spe	cify)
0	ing Pt After th uneral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o Injury	Work		28d. Describe how	injury occurred	
<u>s</u>	death death ctor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home farm str		es 2 No	28f. Location (Stre	et and Number or Ru	ural Route Number
<u>S</u>	al or / s after il Dire d in by	Certification:	4 Homicide determined	building, etc. (Sp.	pecify)	.,, 51100		City or Town,		
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my er: On the basis of exar	knowledge, deat	h occurred at the time	e, date and place,	and due to the cau	ise(s) and manner as	s stated.
	the hin 24 the F	Medicai	29b. Signature and title of certifier	and manner stated.		29c. License		72.0	d. Date signed (Mont	
	5 1 × 1 × 1		Numer 4 X	1.000 9.001	1# W/S	1/1	1444	.3	-28-06	· · · · · · · · · · · · · · · · · · ·
			30. Name and address of person who cor	npleted cause of death	(Item 23a) (Type.	Print)	071(	01 0	-28-06 hmore, MA	2 /
	7		Nina F. Mile	s Everet	+, MD	2323	Or leans,	it, Ball	nove, the	21224
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	and it				

			State of Maryland Department of Health and Mental Hygiene  1 - For Amend Item#8 per FH G853 3/26/06 Of Officate of Death  Registrar  Reg. No.   9	591
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 12  2. Date of Death Month Day Year 12	e of Death
	Examir Funeral Director	er	Oak Crest Village Care Center  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Indicated the security Number of Sex (Months Days Hours Min. (Month, Day, Year)  1 Indicated the sex (Months Days Hours Min. (Month, Day, Year)	te or Foreign
	ס	tor	213-14-9940   85   97/77/1920   Maryian	PCity Limits Yes 2X No
	ath with the 23a or 28a ust be notif	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  8810 Walther Boulevard, Apt. 317 21234 U.S.A.	
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diest Exertinet rust be neithed at	by	1 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩ TT	) <sub>0</sub>
21215-0036	e filed within 72 h al Hygiene. I other than "natu vent, I've Madica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work one during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)  16b. Kind of Business/Industry  Elementary School Principal Education	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Enaminal Traust be natified at	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
	Pages 1 and 2 and 1 ent of Health arent if item 27 is		Marie M. Peters (wife)  8810 Walther Boulevard, Apt. 317 - Parkville I  20a. Method of Disposition 1 \text{\substitute{T}}\text{Burial 2 Cremation 3 Removal from State}  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location · City or Town, State	•
Baltimore,	permit. Pag Department Importent: any injury once.		Parkwood Cemetery 03/27/2006 Baltimore, Maryl 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road – Kingsville, Maryland	
	Physician /Medical Examiner			mate Between nd Death
8760,	icate be executed physician and s the burial-transit	Ical Examiner	Sequentially list conditions, if any leading to in notice cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Custofor as a consequence of):  c. Due to (or as a consequence of):  d.	
.O. Box 68	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
S, D	The law requires that the death ate has been signed by the atte page 2 should be detached for	þ	and the state of t	of death?
Vital Record	n: The law r ficate has be or, page 2 sh	e Completed	or We would be added	gs available of cause of
of	To the Hospital or Attending Physicien: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ToB	examiner?  1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Aurising Home 5   Residence 6   Other (Specify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route No. City or Town, State)	umber,
	To tha Hos within 24 ho To the Fun completely i	Medical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year	
Annual and	011		30. Name and address of person who completed cause death (Item 23a) (Type, Print)  1 MUCE DEWENTHAT MI 8800 WAITHER BW)  ALCOLOGICAL MICHAEL MICHAEL MICHAEL MICHAEL BWO MAITHER BWO MAITH	
	Sta Registr		31. Date filed (MorgaAR 22") 2006 32 Segistrar's Signature	

Locien F. Peters 03/03/06 16:30 PM

			For State Registrar		State	of Mai	ryland		artmen rtificat				ental Hy	giene Reg. No.	006		9592
			Decedent's Name (First, Mi	ddie, La	st)						VII		2. Date of De	ath			3. Time of Death
	Physicia		ANNA		PELLE	CRI	Ni						Month	Day			1450 M
	/Medic Examin		4a. Facility Name (If not institu	tion, giv			,		4b. City,	Town, or	Location	of Death	11000		County of D	-	. 120
	LXamm		JOHNS HOPKINS				4 CE	NIER		Bar	TIM	OPE		-			
	Funeral		5. Social Security Number	6. S	ex		(In yrs. ias		If Under		If Under Hours	24 Hrs. Min.	8. Date of Bir	th Yeas)	9. [	3irthpla	ice (State or Foreign
	Director		214-16-8918	1	□M 2 <b>7</b> F		91	Yrs.	INOTATIO	Cays	110010	10141	Nov. 1	υ, Τ	914	Mar	ÿland
	pu k		Usual Residence of Decedent  10a, State 10b, Cou	ntv			10c. City, 7	Town or Lo	cation							10	d. Inside City Limits
	sho	5		,			•	imore									NXYes 2 □ No
	the N	ect	MD				Dait.	THOLE		Code				10g Citis	zen of What	Counti	~?
	with	by Funeral Director	4206 Berger	Aven	ue				212						U.S.A.		,.
	ne 23	era	11. Marital Status		12. Was De	cedent Ev	ver in U.S.	13.	Was Dece	dent of Hi	spanic Or	rigin? (Spe	ecify Yes or No	D- 1	14. Race - A		
2	or Item	Fū	1  Never Married 2  □  Never Married 1	Married	Armed F	24 No				€			Rican, etc.)		Black, W		tc. Lite
3	al', o		3 ☐ Widowed 4 ☐ Divor	ced	If Yes, G Year or	Dates:			1 🗆 Yes	ZAS NO	Specify	:			Specify:	,,,,	
ה ה	72 hc	Completed	15. Dece (Specify only high	dent's Ed	ducation de completed	1)		16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	st of work	ing	16b. Kir	nd of Busine	ss/indu	ustry
V	ithin	du du	Elementary/Secondary (0-1	-		(1-4or 5+				se retired	)			Off	ico		
7	led w lygier her ti	ខ	12th	de Lane	1			Secre	tary		10 Moth	or's Name	(First, Middle				
2	be fi	Be	17. Father's Name (First, Mide Pasquale Pel										a DiBon		Juliiailie/		
ž	d Mer nark	P	19a. Informant's Name/Relati					10b Maili	na Addros	Cfront (			i Route Numb		Tour State	a Zin /	Codel
Š	d 2 sl th an 7 Is r traur				•		- 1		3	•			altimor				5000)
ָ ע	1 an Heali em 2		Francina Cri 20a, Method of Disposition	tzma	n/n1ec	e		ce of Disponetery, crea					Date		cation - City		vn, State
2	ages nt of t: If It		1 NBurial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe			n State	1				1	02.2	0.06	Da1	+-1	. 1	€ T
allillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Euneral Sen				Hol	y Red				03-2	9-06 ler-Dip		timore Funera		
Ö	Depar Impo any it		16	-	3		>						Baltimo	-		1206	
			23a. Part1. Enter the disease	, or com	plications that	caused t	he death.					-					Approximate Interval Between
	Physician		shock, or heart failure. Immediate Cause (Figure	EISLOTHY	one cause on			-: - 0	. i Δ								Onset and Death
	/Medical		disease or condition resulting in death)	-	a Due to		conseque		V P	NEU	M.01	MIA				+	
	Examiner			-1	b												
`	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	Due to	o (or as a	conseque	nce of):			-						
9	nd	Examiner	Cause (Disease or injury that initiated events	1	c												
Š	be execu icien and burial-tra	Ä	resulting in death) Last		Due to	o (or as a	conseque	nce of):									
9700,	icate be executed physicien and s the burial-transit	dicai			_ d											+	
٥ ×	ding p	Me	IF FEMALE:		23c. If yes, o	utcome o	f pregnanc	71/							2015	4.0	
XOO O	death certifi e attending od for use as	cian/Me	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live	birth 2	Petal deal	eath 3[	□Ectopic p □ Other (s					2	23d. Date of Month		y Day Year
j	wrequires that the death certif been signed by the attending should be detached for use as	Physic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unk		inte or dea	iui 3(	_ Cillel (s)	Decily)							
ŗ	The law requires that the ste has been signed by th page 2 should be detache	된	Part II. Other significant con	ditions	contributing to	death but	t not resulti	ing in the u	inderlying	cause givi	en in Part	1.	23e. Did	tobacco u	se contribut	e to the	e cause of death?
g,	uires sign ld be	d by											10	Yes 2	□No 3 [	Proba	bly 4 □Unknown
COS	w req	lete											24a. Wa	s an	24b. Were	autop	sy findings available
T T	he la e has	Completed												ormed?/	death	h?	sy findings available inpletion of cause of
VICAL	ding Physician: The lav h. After this certificete has funeral director, page 2	ပိ	25. Was case referred to me	dical							26 Plac	e of Deat	1 ☐ Yes		101	es a	2□ No
	ysicia s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatien	t 2 EF	R/Outpatie	nt 3 D	OA Oth	0.0		me 5□Res	-	6 □Other (S	Specify.	)
5	g Phy er thi		27. Manner of Death		28a. Dat	e of Injury	/ 2	8b. Time o	of	28c. Injun Worl			28d. Describe			,,	
0	ttendin death. tor: Aft the fun	atio	1 Matural 5 ☐ Pe 2 ☐ Accident inv	nding estigatio		nin, buy	7007)	піјату	М		Yes 2□	]No					
UNISION	Atte er de recto by th	ertification:		uld not b termined	289. Plat	ce of Injui	ry - At hom (Specify)	ne, farm, st	reet, factor	y, office				(Street and		Rural	Route Number,
5	ital or rs aft ral Dii	Ce															
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the funeral director, to		(Check only 2 Med	ifying Pl	hysician: To ti minar: On the	basis of	examinatio	ledge, deat on and/or in	th occurred	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the	cause(s) , date and	and manner place, and	r as sta due to	ited. the cause(s)
	the I	Medical	one)		and ma	anner stat	ed.						1		e signed (M		
	To Yell		29b. Signature and title of ce	16	Je =			0	1						,		
	7			200	المحر لل	И		· clen			157	000		3	1261	06	
	10		30. Name and address of per							=0			RAI	T) 100	an F		D 21224
	Sta	ite	31. Date filed (Month; Day, Y			Registra	r's Signatu		ASTE	-1-2	AVE	NUC	0/7-	(1///	J. 42,	11.	U 41 LLY
e <sup>c</sup>	Regist		MAD	2 0	2006	40		M.	hours	1							
			THE STATE OF THE S	N		A 500 1216	2.00	g: H = R	Water William . The								

			For State Registrar			d / Depa		ealth and Note that the second	Mental Hyg	_	) 6	09593	
1	Physici		1. Decedent's Name (First, Middle, Last)  Earl G. Reuling			·			2. Date of Deat March 27,	h	Year	3. Time of Death 8:02 P. M	
	/Medic Examin		4a. Facility Name (If not institution, give s Gilchrist Center	treet and numb	er)		4b. City, Town, or Baltimor	Location of Death		4c. County	4c. County of Death Baltimore		
p.m.	Funeral Director			M 2□F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 30,				
8:02pm	the Maryland 28a-1 show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Carroll Manchester								1	0d. Inside City Limits 1 X Yes 2 ☐ No	
2006	with the M se or 28a-f	I Direc	10e. Street and Number 3332 Main Street				10f. Zip Code 21102		*	0g. Citizen of	What Cour	ntry?	
7	within 72 hours after deeth with the Maryland with a Y2 hours after deeth with the Maryland ene. than "retural", or items 23a or 28a-f ahow he Marified a how he Marified a land.	by Funeral Director		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	XX No			ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		an Indian, etc.		
serling read march	within 72 hours igne." r than "natural", in Madical Ex.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life. L Carpen		ation during most of work	king		Improvement Co.		
- Cond	Mally Idlin 2.12. 2 should be filed within and Mental Hygiene. 7 is marked other than reumatic event, the Mental Control of the Ment	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maider) Su  19. Albort Pouling Desifore										
Gard	ie, malyla s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (Ty George Reuling/Son	pe, Print)			g Address (Street and Avenue	and Number or Rui		City or Town	, State, Zip	Code)	
ing	Pages 1 a ent of Hez nt: if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from St			sition (Name of natory or other place 1ey Mem. G		Date 31/06	20c. Location Timoniu			
Revling	Dallillore, Mapper permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other traugone.		21. Signature of Funeral Service License	-Christin	a L. Hil	ton   22	Name and Addre eonard J. 1 305 Harford	ss of Facility Ruck, INc. d Road Bal	timore Mar	vland 2	1214		
0	Physician /Medical Examiner and physician and physician and the brutal-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence as a c	Struence of):	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death Must have	
3	F.C. BOX 601 that the death certificate ed by the attending phyy detached for use as the	ıysıclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 □ Fetal nt at time of de	death 3	Ectopic pregnancy Other (specify)		73		ate of delive onth	ery Day Year	
	The law requires that the law requires to that the law seen signed by page 2 should be detact	Completed by Physician/Medi	Part II. Other significent conditions con  AN AL MY!  YCMA ( FAC	ntributing to dea COMA LUV-E		ulting in the u		en in Part I.	1 ☐ Y	es 2 No in 24b.	3 Prob	opsy findings available mpletion of cause of	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of (Month,	Injury Day Year)	ER/Outpatien 28b. Time of Injury ome, farm, str	28c. Injur Wor	er: 4 🗆 Nursing H	th (Check only or ome 5 Resid 28d. Describe has 28f. Location (S City or Tow.	ence 6 20th ow injury occu- treet and Num		y) Hospice	
	Hospitel or 24 hours efte Funeral Diri	Medical Ce	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exami		is of examinat								
	To the within 2 To the complete	Me	29b. Signature and title of certifier	Rile	y our	9	29c. Licens	e number	- 2	9d. Date signe	h 2	Day, Year)	
	6		30. Name and address of person who co	empleted cause	of death (Item	1 23a) (Type,	Print) les S	+. Bolt	E. Mel	212	0/2		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Re	gistrar's Signa	ture	K)						

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month 3 **Physician** 10:25 PM e5017 Unier 00 /Medical Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aney Interior If Under 24 Hrs. Date of Birth (Month, Day, 6. Sax 7. Age (In yrs. last birthda) **Funeral** Days Hours Min -54-8/1 1**€** M 2□ F Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No by Funeral Director 10 10g. Citizen of What Country? Street and Numbe 10f. Zip Code ō 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3190 3 ☐ Widowed 4 ☐ Divorced "neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) onstruction 17. Father's Name (First, Middle (First, Middle, Maiden Sumame) Be obeson ပ Niece 3502 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trek once. 40/mes Place of Disposition (Name of Jenetary crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Disease ena /Medical Due to (or as a consequence of) Examiner per Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident Injury death. 1 TYes investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2300 Dulaney Valley 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood Timonium 31. Date filed (Month, Day, Year) gistrar's Signature

State

Registrar

MAR 2 9 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 March 25, 12:00 pm Shirley Nadine Rinker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Middle River Baltimore 2108 Redthorn Road If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 □ M 2X F Yrs. Maryland Director May 17, 1935 214-34-1552 70 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow r then "natural", or iteme 23e or 28a-f eho: the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U. S. A. r death 2108 Redthorn Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes ZX No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify β 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! Pages 1 and 2 should be 2 Lucas Bertha Idleman Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Heelth ar Important: If item 27 is any injury or other treu 139 Hampshire Road Essex, Maryland 21221 Carletta Jones (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3/28 2006 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver disease End STAGE **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner nding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by iArtheA Status post ples procedure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of pertifier cry) 30. Name and address of person who completed cause of death (I)em 33a) (Type, Print) harles St. Balto Md 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature,

CHELLES

9 2006

		For State Registrar	lease I			nd / Depa	artmen	t of Health e of Deat	and M				09596	
Physicia		1. Decedent's Name (First, I	diddle, Last)	Rems	berg			0, 500.		2. Date of 0 Month March	Death		3. Time of Death 9:35 P.MM	
/Medic Examin		4a. Facility Name (If not insti Frederick						Town, or Location	on of Death			4c. County of Death Frederick		
Funeral Director		5. Social Security Number 213-24-9382		7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year If Und Days Hour			Day, Yea.	Year) 9. Birthplace (State or Foreign Country) 1921 Maryland		
Maryland -f ehow	tor	Usual Residence of Decede  10a. State 10b. Co  Maryland Fred	unty			ty, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 📉 No	
with the	Directo	10e. Street and Number			TILE	deliek	10f. Zip					citizen of What C	ountry?	
15-0036 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow calcal Examinations in rectified at	by Funerai	5734 Box Elde  11. Marital Status  1 X Never Married 2  3 Widowed 4 Dive	Married	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	∍s? XNo		217 Was Deced If Yes, spec 1 ☐ Yes	dent of Hispanic offy Cuban, Mexi		ecify Yes or f Rican, etc.)	USA No-	14. Race - Ami Black, Whi Specify: Wh:	te, etc.	
15-0	Completed	(Specify only I		completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupation rk done during m se retired)	nost of worki	ng	16b.	16b. Kind of Business/Industry		
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental hygiene. It is marked other than "natural", or traumatic event, it e Medical Exer-	Be Com								other's Name	(First, Mida		ail Flo	wer Shop	
arylan should be nd Mental marked c	Louis Henry Remsberg  Althea Mary Brown  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi,										T- 0-41			
		Charlotte Cra				.1						faryland		
Solution	Ē	20a. Method of Disposition 1 🖫 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from Sta	ate	Place of Dispo cemetery, crer	natory or c	ther place)	1	oate		Location - City or		
Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Funeral-Se	rvice License	90 21 621	M00	22	2. Name ar	d Address of Fa	cility Kee	ney ar	nd Ba	sford F	, Maryland uneral Home aryland 2170	
Physician		23a. Part . Enter the diseas shock, . heart failure. Immediate Lause (Final disease or condition		cations that cau	sed the deat	th. Do not ent	er the mod	e of dying, such	as cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death	
Medical Medical Medical Personner Medical Personner Medical Me	lical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or	as a consect as a consec	quence of):	/ASC	HEMO	A	CIDE	NT	•		
Hecords, P.O. Box 687. The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 moriths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown						egnancy ecify)	-		-	23d. Date of delivery Month Day Year		
cords, P.	ρ	Part II. Other significant co	nditions con	tributing to deat	th but not res	sulting in the u	nderlying o	ause given in Pa	art I.		d tobacco		o the cause of death?	
	Completed									24a. Wi au pe 1 🗆 Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of	
VITAL F	o Be	25. Was case referred to me examiner?  1  Yes 2 No		lospital:	atient 2	ER/Outpatier	nt 3 D0	Othor		Check on		6 □Other (Spe	acity)	
DIVISION Of VIta or Attending Physicien: after death. Director: After this certific d in by the funeral director.	- 1	27. Manner of Death	ending vestigation	28a. Date of		28b. Time o		Bc. Injury at Work?	- 1			ury occurred	, and the second	
DIVISIO	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)					reet, factor	, office			(Street a		lural Route Number,	
DIVI:  To the Hospital or Att within 24 hours after d  To the Funeral Direct completely filled in by	edicai (	29a. Certifier 1 Con (Check only one) 2 Me	titying Phys dical Examir	nician: To the basi ner: On the basi and manner	is of examina	owladga, dast ation and/or in	hoccurred vestigation	et the time, data , in my opinion, o	and plane, t death occurre	and due to the ed at the tim	a czusel e, date a	a) and mannar a nd place, and du	e to the cause(s)	
To the within 2 To the complei	Ž	29b. Signature and title of c	artifier				290	00 4 T	95 l	,	29d. D	ate signed (Mon	th, Day, Year) 2006	
8		30. Name and address of personal control of the con	rson who co	mpleted cause	of death (Ite	m 23a) (Type,	Print) H	xuse Aug	- FR	EDER	UCK	. mo	21701	
Sta Registr		31. Date filed (Month, Day,	Year) 208			ature								

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #20a&b Per FH G853r0f/29406f DMath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** MARY RICE 5:00 AM 2006 15 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABALTIMORE UNION MEMORIAL HOSPITAL 5. Social Security Number 4 ZZ-14-338 Z 8. Date of Birth
7-29-1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕁 F ALABAMA Yrs 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Directo N/A BALTIMORE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code r then "natural", or items 23s or tre Medical Examinar must be 1300 E. LANVALE ST. APT 407 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. ☐ Yes 2 7 No Yes, Give X 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD WAITRESS 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN 17. Father's Name (First, Middle, Last) UNKNOWN Peges 1 end 2 should be fill ment of Health and Mental H tent: if Item 27 is marked off lury or other treumatic even 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) THOMAS TAYLOR (COMPANION) 1300 E. LANVALE ST. APT 407 BALTIMORE, MARYLAND 20h. Place of Disposition (Name of Memetery) on alor cens carry 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State permit. Peg Depertment Important: i eny injury o 3-23-2006 BALTIMORE, MARYLAND METRO CREMATORY 21. Signature of Funeral Service Livensee ONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock of heart failu Immediate Cause (Final disease or condition Physician Chronic Renal 30473 /Medical resulting in death) Due to (or as a consequence of): Examiner Coronar 30423 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and s the burial-transit death certificate be executed Hoperlenker that initiated events resulting in death) Last Due to (or consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 XUnknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ဥ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation М i Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 ☐ Homicide 24 hours 1 🔀 Certifying Physician: To the best of my knowledge, death conurted at the time, date and place, and due to the natise(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) phsici AT 2438946 M.D March 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAJAHATH MO memorial Hospital MOHSINI Union 31. Date filed (Month, Day, Year) MAR 2 9 2006 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and N  1- State State Certificate of Death	-	giene	06 09598
			Decedent's Name (First, Middle, Last)	T	ath	3. Time of Death
_	Physici /Medic		Howard Franklin Sample, Sr.	2. Date of De	2 C 20	Year 7-52 A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	h	4c. County	of Death
			Franklin Square Haspital Rosenal &		Balt	imole
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bin (Month, Da	th v, Year)	Birthplace (State or Foreign Country)
	Director		214-56-4518 84 Yrs. 54 Yrs.	March 1	3,1952	Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	anyli •ho	ក	Maryland Baltimore Middle River			1 □ Yes 2 CXNo
	ith the Marylar or 28a-f ehow e notitied at	ect	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Country?
	with	ă	12928 Harewood Road 21220		U.S.A.	mat obunity.
	death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Si	pecify Yes or No		e - American Indian,
(0	or Ite	Ē	1 □ Never Married 2⊠ Married 12⊠ Yes 2 □ No 1970 —	o Rican, etc.)	Blac	ck, White, etc.
0036	within 72 hours after ane. then "naturel", or Ite	l by	3 □ Widowed 4 □ Divorced   If Yes, Give Year or Dates: 1973   1 □ Yes 2 ★ Yes Specify:		Specify	" White
5.0	72 h	etec	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	rking	16b. Kind of Bu	usiness/Industry
<u>7</u> 2	Althin ne. hen.	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		Gament	
> 2	led w fygier her ti	ပိ	12 Carpenter  17. Father's Name (First, Middle, Last) 18. Mother's Name	no /Fires stintelle	Constr	
E) HOWEL	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiene. Importent: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehov any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by	Harry Sample, Sr. Muriel He			·e/
工艺	should nd Men marke marke	۲۵	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			State Zin Codel
<b>∑</b>	d 2 s ith an 27 ie trau		Janet Sample (Wife) 12928 Harewood Road, I			
ē _ ē	Heal tem 2		20a Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
Sam P	ages ent of nt: If I		1 Burial 2020 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  accemetery, crematory or other place)  Bayview Crematory, Inc. Marc	ch 30 20	06 Balt	imore Maryland
. ਰ ≣	nit. F partmoorter Injur					
~ W	Depa Impo any I		21. Signature For grad Service Indiana 22. Name and Address of Eaclify Bruzdzinsk: 1407 Old Eastern A	ı Funera Avenue	I Home,	P.A. Maryland 21221
		-	23a. Part1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions h HxPertension			
7	ש ש	Examiner	Sequentially list conditions, if any, reading to minimize the cause. Enter Underlying Cause (Disease or injury			
V	and and I-trans	am	that initiated events C.			
760,	ite be executed iysicien and ne buriat-transit		Due to (or as a consequence of):			
		dlcal	d.			
9 ×	death certifical attending phi d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		224 0-4	ha af dafina.
Bo	atten for u	clan	in the past 12 months?		230. Dat Mor	te of delivery nth Day Year
o.	that the de ed by the detached	ysk	1   Yes 2   No 9   Unknown 9   Unknown			
σ,	ires that the signed by	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contr	ribute to the cause of death?
rds	quires n sign	Q D		10	Yes 2 □ No	3 Probably 4 Unknown
8	Attending Physicien: The law requires that the death certifics in death. If death. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physician/Med		24a. Was	an 24b. V	Were autopsy findings available
æ	hysician: The law his certificate has t il director, page 2 s	E			osy p	prior to completion of cause of death?
ta	tifical	BeC	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes	-	1 ☐ Yes 2 ☐ No
<u> </u>	Physici this cer al direc	To B	examiner?		dence 6 □Othe	er (Specify)
0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1. ✓ Natural 5 ☐ Pending (Month, Day Year) Injury Work?		how injury occurr	
<u>.</u>	endir sath. or: Al	atlc	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O. Box 68	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox		er or Rural Route Number,
	urs al	ပီ				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: To the best of my knowledge, death occurred at the time, date and place (Check only one)	n, and due to the arred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To t Com	Σ	29b. Signature and title of pertition 29c. License number			d (Month, Day, Year)
	الور		DOOT 9853		3-26	-6
	107'		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DIBETSY SCHOOLEN 9000 From KIN Square Drive	Baltim	ore, M	021237
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 9 2006  32 Registrar's Signature		,	

			1 - State Registrar	State of Ma	aryland		rtment o			-	giene Reg. No.	006	09599	
		, Sg	Decedent's Name (First, Middle, Last)							2. Date of De	ath	V	3. Time of Death	
# 10	Physici /Medio		Theresa Shugars							March	21, 2	.006 Year	6:13 p <sup>M</sup>	
4	Examin		4a. Facility Name (If not institution, give s				4b. City, Tov	vn, or Loca	ition of Dea	th	4c. (	County of Dear	th	
			1014 Wilmington Ave		e (In yrs. ias	t histodoul	Baltimore  Hav) If Under 1 Year   If Under 24 Hrs.   8.				N/	the land (Chata and Farrian		
.3	Funeral Director			M 2€F	83	Yrs.			urs Min		y, Year) 192	Co	thplace (State or Foreign puntry) Vland	
- P	70		Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County MD N/A		Balti	Town or Loc	cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the M 28a-f	ecto	10e. Street and Number		Dait	LIIIOLE	10f. Zip Co	do.			10a Citiz	en of What Co	21	
	with 3a or	Funeral Director	1014 Wilmington Ave	nue			21223			ī	J.S.A		only:	
	death ms 23	Jera		2. Was Decedent Armed Forces?		13. V	Vas Decedent	of Hispani	ic Origin? (	Specify Yes or No		4. Race - Ame		
39	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23e or 28e-f ahow attc avant, Ira Medical Exertinal musi be rodified at	þ	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	<b>Y</b> 0	1	ecify:	rto Rican, etc.)		Black, Whit Specify: wh					
- 2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of working					d of Business	findustry			
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5		life. D	OO NOT use r	etired)	illosi or we	nnig.				
2	led w tygier her th		17. Father's Name (First, Middle, Last)		5	Sales	Clerk	10.4	Mothar's No	me (First, Middle	Reta			
Maryland 21215-0036	should be find Mental harmarkad of	Joseph Niser Alma Keefer									Majuerrs	oumame)		
, Mar	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23e or 28e-f show or other traumatic avent, the Modical Examinar must be notified at		19a. Informant's Name/Relationship (Туд Gloria Kline/Daught		1					Rural Route Numb			Zip Code)	
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other traconce.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cerr	netery, crem impre	sition (Name of atory or other Nation	r place)	3-24	Date -2006		ation · City or imore,		
Balti	permit. Departm Importa any inju		21. Sunature of Funeral Syrvice License	Dura	and	/ An	etery Name and A Ibrose	Euner	Facility	ome of La	nsdo	wne		
			23a. Part1. Enter the disease, o complice shock, or heart failure. List only on	ations that cause	the death.	Do not ente	er the mode o	f dying, suc	ch as cardia	ac or respiratory a	rrest,	wife MD	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acu	te a conseque	Myx				kemi.			Onset and Death I month	
7	Examiner		Sequentially list conditions b		a conseque									
Ø	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):								
ر ر	rate be executed by sician and the burial-transit	Exan	that initiated events c resulting in death) Last	a conseque	nce of):	ice of):								
8760,	icate be ex physician s the buria	dical	<b>€</b> d											
9	ntifica ng ph as th	Med	JF FEMALE:											
.O. Box	The law requires that the death certific site has been signed by the ettending prage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unk								2:	23d. Date of delivery Month Day Year		
Δ.	that I	by Ph	Part II. Other significant conditions con	tributing to death b	ut not resulti	ing in the un	nderlying caus	e given in 1	Part I.	23e. Did 1	obacco us	se contribute to	the cause of death?	
rds	quires in signi									10	Yes 2	Wo 3□P	robably 4 Unknown	
Division of Vital Records,	ne law requir has been si ge 2 should	Completed								24a. Was auto perfo	osv	24b. Were at prior to death?	utopsy findings available completion of cause of	
a	ician: The l certificete ha rector, page	ပို	25. Was case referred to medical					20	Disease of Da		2 No	1 🗆 Yes	2 No	
5		0 8	examiner?	ospital:	ent 2∏EF	R/Outpatieni	t 3□DOA			Home 5 Resi		□Other (Spe	cutv)	
o u	ling Phys	lon: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 2:	9b. Time of Injury	28c.	Injury at Work?		28d. Describe				
isio	death. death. ctor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	upy - At hom	a farm stre	M factory of	1 Tes	2 🗆 NO	28f Location /	Street and	Number or R	ural Route Number.	
<u>&gt;</u>	itel or A rs after al Directed in by	Certification;	4 Homicide determined	building, et	c. (Specify)	e, iaim, sile	set, lactory, or	ilice		City or To		Trumber of the	arai noute ivaniber,	
	To the Hospitel or Attending Phwibin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physics (Check only one)	ician: To the best er: On the basis o and manner st	t examination	edge, death n and/or inv	occurred at t restigation, in	he time, da my opinion	ate and place n, death occ	ce, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	s stated. to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier	Cul Mr.	·			cense num				signed (Mont		
	5		30. Name and address a person who co	erick R	d - 5	VITE	Print) S	haro	n J	. Mc 60	r~201	KMA	3,2006	
10 300	Sta		31. Date filed (Month, Day, Year)		ar's Signatur	re								
84	Registr	ar	MAR 2 9 2006	Magnes	M.	ADBAK.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dale of Death 1. Decedent's Name (First, Middle, Last) Month

City, Town, or Location of Death

stevenso

3. Time of Death

Physician	
/Medical	
Examiner	

For State Registrar

4a. Facility Name (If not institution, give street and number)

1-

**Funeral** Director

the Maryland r then "natural", or iteme 23s or 28s-f ehow the Modical Examinar must be notified at

72 hours after permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "na ery injury or other traumatic event, Ina Madia 2006.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760

Division of Vital Records.

ed by the attending physician and detached for use as the burial-transit certificate has been signed by i Hospital or Attending Physician: 24 hours after death. After this certific funeral director, s after dec.

sture isterta nernu If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 M 2 F Yrs. 81 215-90-3987 Mar 1, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No Baltimore Director Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 721 Main Street 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: ģ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk | 16b, Kind of Business/Industry unk 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Future Care Cherrywood 12026 Reisterstown Road Reisterstown, No. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒ Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee ractor Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) congestive Heart Failure Due to (or a a consequence of): Jalvular Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď abstructive pulmonary Disease 1 Yes 2 No 3 Probably 4 Dunknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Fibrillation Atrial 1 Yes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ENatural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Marin J. 00058676 March 21, 2006

State Registrar

24 hours a

within 2

sperter

suite 200

Re isterstown

25 Moin Street

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen L. Bayitt

MAR 2 9 2006

31. Date filed (Month, Day, Year)

		•	For State Registrar		State of Ma	ıryıand				ieaith i Death			glene Reg. No.	16	09601	
	Dhuaisi		1. Decedent's Name (Fi	irst, Middle, Last	)							2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici /Medio		Richard R	. Stern	S							March	h 23, 2006 11:05			И
}	Examir	er	4a. Facility Name (If not							Location			4c. Count	of Death	n	
			Holy Cros			// /-	-11:45-6		ver :	Sprin			Montg			
	Funeral		5. Social Security Numb	4.5	x ZM 2□F 7.Age		nst birthday) Yrs.	Months		Hours	Min.	B. Date of Birt (Month, Da			nplace (State or Foreiguntry)	ηn
	Director	}	577-50-318 Usual Residence of Dec	0		70						Aug 16	, 1935	Wasl	hington	
	/land			b. County		10c. City	Town or Lo	cation							10d. Inside City Limit	s
	Man	ţ	MD N	Montgome	ry	Si	ilver :	Sprin	.g						1 ☐ Yes 2 N	0
	1.28g	Director	10e. Street and Number	r				10f. Zip	Code				10g. Citizen of	What Co	untry?	
	15 wit	alD	1817 Sanford Road 20902										US	٠.٨		
	dea	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S	S. 13. V	Vas Deced	lent of Hi			ify Yes or No- ican, etc.)	14. Ra	ce - Amer	ncan Indian,	
326	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show or other treumatic event, Ira Madical Examinar must be redifficated.	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:	0	1		Yes 2∏ No Specify:				Black, White, etc.  Specify: White			
Maryland 21215-0036	2 hot	te d	15.	Decedent's Edu	cation		16a. Deced	ent's Usua	I Occupa	ation			16b. Kind of B			12
2	n nin 7.	Completed	(Specify o	· · · · · · · · · · · · · · · · · · ·	ide completed) (Gir			e kind of work done during most of work DO NOT use retired)			st of working	7			, un	.r.
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<u>a</u>	should be Ind Mental I	2	Mandron R	ichard S	Sterns					Fan	ny Ju	liana 1	Leppane	n		
a	2 sho and ie mu		19a. Informant's Name/	Relationship (T)	rpe, Print)		19b. Mailin	g Address	(Street a	and Numb	er or Rural	Route Numbe	er, City or Town	State, Z	ip Code)	
≥	and sealth m 27 m 27 her tr		Ronald Ste	<del></del>	ther	1001 51							ng, MD			
0	t of H if ite		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - Cit										on - City or Town, State			
Ξ	ment tant: jury		4 ☑Donation 5.□	Other (Specify)	1					i						
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funera Ron		ade vire	geor	St		nato	ss of Facili Omy B MD		655 W.	Baltim	ore	Street	
П			23a. Part 1. Exter the di	isease, or compl	cations that caused ne cause on each line	the death.						respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Fina disease or condition		termin		ino cai	ncar							Onset and Death	
	/Medical		resulting in death)		Due to (or as a			icei								
	Examiner		Sequentially list condition		post of	bstru	ctive	pneu	moni	a						
-	D ==	iner	Sequentially list condition any, leading to immediate. Enter Underlying Cause (Disease or injur													
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o a	w requires that the death cerbeen signed by the ettendin should be detached for use	cian/M	23b. Was decedent pre- in the past 12 mon	nths?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal o	death 3	Ectopic pr						ite of deliv onth	very Day Year	
j	the de	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	9 Unknown	HILD OF GEN	atii 5	Other (sp	эспу)							
7	requires that the een signed by th nould be detache	된	Part II. Other significan	it conditions co	ntributing to death bu	t not resul	ting in the un	derlying ca	ause give	en in Part I	I.	23e. Did to	bacco use con	tribute to	the cause of death?	
g.	uires sign d be	d by										1 🗆 Y	es 2□No	3 000	bably 4 Unknow	'n
Cord	law requir es been si 2 should i	iete										24a. Was	an 24h	Were aut	topsy findings available	le l
r	rsician: The law s certificete hes t director, page 2 s	Completed										autop perfoi	med?	prior to c death?	ompletion of cause of	٠
	ifficet or, pi	0	25. Was case referred t	o medical						OF Place	of Dooth	1 ☐ Yes Check only o	-	1 ∐ Yes	2 No	
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ō	ding Phys h. After this funeral di		27. Manner of Death		28a. Date of Injury	/	28b. Time of		8c. Injury Work				ow injury occur		און עכטוז מיי	LU
Vision	ndin ath. r: Aft e fun	atio	1 ☐ Natural 5 2 ☐ Accident	Pending investigation	(Month, Day	( Bai)	Injury	М		<br Yes 2 ☐	No					
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hon (Specify)	ne, farm, stre	et, factory	, office		28	If. Location (S City or Tow		oer or Rui	ral Route Number,	
2	oital o urs aff erai Di										-2.5	UKS STATES VIDE			-111-5300101011	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edicai	29a. Certifier 1 (Check only 2 one)	Medical Exami	sician: To the best of her: On the basis of and manner stat	examınatı	rledge, death on and/or inv	occurred estigation,	at the tim in my op	ie, date an pinion, dea	nd place, an ath occurred	d due to the o	cause(s) and m date and place,	anner as and due	stated. to the cause(s)	
	To t To t	ž	29b. Signalure and title	of certifier	20 II			29c	License	number			29d. Date signe	d (Month	, Day, Year)	
		x	Mucs	VILOX	Kaka	161		D	006	3390			March 2	3. 2	006	
			30, Name and address	of person who co	ompleted cause of d	th (Item	23a) (Type, I		×	time	0		A. Asse	Jm	OFFICE AND A	
		-	31 Date flood (Marty )	JI CA	fany	116	uch	RA	No.	JULY.	Lon	4 7	Deliver	pr	ing in	
	Sta Registr		31. Date filed (Month, D	2 9 2006	82. Registral	r's Signati	Social	مع المع						/	U	

CPM 06-021	l19 ance Se	70 h	<b>Please</b> vick Unpenditen#2	Type or Print in I 3a,27,28a f perMF State of Marylar	Black Ind	elible Ini	k. Ensure	All C	Copies A	re Legible	·.
COLISCA	arice be	ugv	1 = State Registrar	Stafe of Marylar		rtment of ificate of		Mer		ene J. No: 000	09602
	Physici /Medic		Decedent's Name (First, Middle, La	stance Sed	awick		-		Date of Death Month Iarch	Day Yea 26, 200	3. Time of Death 18:20 M
0	Examin		4a. Facility Name (If not institution, gir Harbor Hospital (			-	or Location of Dea	ith		4c. County of D	eath A
3	Funeral Director		5. Social Security Number 6. 216-76-2972	Sex 7. Age (in yrs.	last birthday) Yrs.	If Under 1 Yea Months Day		3	Date of Birth (Month, Day, ) UNC 10	PARI	Birthplace (State or Foreign Country) Maryland
	the Maryland -28a-f ehow	ctor	Usual Residence of Decedent  10a. State  10b. County  Mayland	10c. Ci	ty, Town or Loc		timore				10d. Inside City Limits 1 □ es 2 □ No
	€ 5 3	ai Director	10e. Street and Number 1206 Cherry	Hill Rd. Ap	t. H	10f. Zip Code	21225	-	100	g. Citizen of What	Country?
036		by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		/as Decedent o Yes, specify Co ☐ Yes 210	f Hispanic Origin? ( ubap, Mexican, Pue o Specify:	Specify into Rica	Yes or No- an, etc.)	14. Race - A Black, W Specify:	merican Indian, Inite, etc. Black
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after If Health and Mental Hygiene. Item 27 Is marked other than "naturel", or its other traumatic event, tre Medical Examinations.	Completed	15. Decedent's Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give k	ent's Usual Occi ind of work dor O NOT use reti	ne during most of w	orking	1	Sb. Kind of Busine Wiversi Hose	iss/Industry  Hy ac Manyla
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	t and 2 shows the and tem 27 lemostreum.		19a. Informant's Name/Relationship  Coston Sedgwic  20a. Method of Disposition	K-husband	19b. Mailing 1206 Place of Disposemetery, crem	Cherry ition (Name of	et and Number or F	Rural Ri Pate	. Apt.	City or Town, State  Ball  C. Location - City	imore, Marylan
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny injury or other once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ify)	butus 1	Mem. H	WK 4	1-1-0	ole A er Fun	eral Ho.	Maryland me, P.A. appl
	405 9 9		23a. Part1. Enter the disease, or conshock, or heart failure. List onto	mplications that caused the dea	th. Do not ente	r the mode of d	ying, such as cardi	A v	e. Bul-	timore, 1	Maryla 2/32 Approximate Interval Between
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	ed sit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):						
8760,	tificate be execu ig physician and as the burial-tra	EX	that initiated events resulting in death) Last	Due to (or as a consec	quence of):		-				
Division of Vital Records, P.O. Box 68760,	• Hospital or Attending Physicien: The law requires that the death certificate be execut 24 hours effer death. • Funeral Director: After this certificate has been signed by the ettending physician and attention by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □l	Ectopic pregnal Other (specify)				23d. Date of Month	delivery Day Year
ds, P.	uires that I signed by Id be deta	d by Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the un	derlying cause	given in Part I.				e to the cause of death?  Probably 4 Nnknown
Recor	To the Hospital or Attending Physician: The taw requires that the death cer within 24 hours effer death. To the Funeral Director: After this certificete has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use	Complete							24a. Was an autopsy performe 1 X Yes 2	ed?   death	e autopsy findings available to completion of cause of 1? Yes 2 \sum No
f Vita	ysician: iis certific director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 Ž	<b></b> ER/Outpatient	3□ DOA	26. Place of D Other: 4 ☐ Nursing		theck only one,		Specify)
ion o	inding Pt ath. ir: After the ie funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigati		28b. Time of Injury Fnd 5:55	28c. In V			. Describe how	injury occurred	
Divis	al or Atters setter de il Directo	Certification:	3 ☐ Suicide 6 🗖 Could not 4 ☐ Homicide determine	28e. Place of Injury - At r building, etc. (Speci house	nome, farm, stre ify)	et, factory, offic	Ce Co		City or Town,	et and Number of State) 1206 ( imore, MD	Rural Route Number. Cherry Hill Rd.
	Nospit 124 hour. Punera letely fille	Medical C	29a. Certifier 1 ☐ Certifying F (Check only one) Medical Ext	Physician: To the best of my kn aminer: On the basis of examin and manner stated	owledge, death ation and/or inv	occurred at the estigation, in m	time, date and pla y opinion, death oc	ce, and curred	due to the cau at the time, dat	use(s) and manner e and place, and	r as stated. due to the cause(s)
	To the Within 2 To the	Me	29b. Signature and title of certifier	` .		29c. Lice	O.C.M.E.			d. Date signed (March 27,	
	Son		30. Name and address of person wh	~ ^			treet, Ba	]†i:			
2.	Sta		31. Date filed (Month, Day, Year) MAR 2 9 20	32 Registrar's Sign	ature						
	Regist	ar	111111111111111111111111111111111111111	106	Apo	de_					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		artment			and Me	ntal Hy	giene	HUD	09603				
			Decedent's Name (First, Middle,	Last)					2	Date of D			3. Time of Death				
П	Physici /Medic		Joh	n Robert Sorre	l1s							2006	6:50P M				
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or	Location o	f Death		4c	. County of De	ath				
			3216 Gold Mine					ille	04 Hrs. I a			Montgomery					
	Funeral			10√M 2□ E	s. last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	Month, D	av. Year)		irthplace (State or Foreign Country)				
	Director		245-26-7685	80					AL	igust 1	9, 19	25 N	orth Carolina				
	/land		10a. State 10b. County	10c. 0	City, Town or L	ocation							10d. Inside City Limits				
	Man	to	Maryland Montgo	mery B	rookevi	.11e							1 ☐ Yes 2X No				
	th the	Funeral Directo	10e. Street and Number			Code				10g. Cit	g. Citizen of What Country?						
	23a	a	3216 Gold Mine	Road		333					United States						
	tems tems	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced If Yes, spec	ent of Hi	ispanic Orig n, Mexican	gin? (Speci i, Puerto Ri	ify Yes or N can, etc.)	lo-	14. Race - An Black, Wh	nerican Indian, iite, etc.				
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ∏Yes 2 XX No If Yes, Give Year or Dates:		1 ☐ Yes 2	No 🌋	Specify:			-	Specify:	White				
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28e-f ehow event, the Madical Examiner must be multiled at	ed I	15. Decedent's		16a. Dece	edent's Usua	I Occup	ation			16b. K	and of Busines	s/Industry				
<u> </u>	n na	Completed	(Specify only highest	grade completed)	(Give	e kind of wor DO NOT us	k done d	durina most	t of working	7			ŕ				
212	r than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	E1	ectric	cal	Engin	eer			Federal	Government				
77	e filed al Hygie other	Be C	17. Father's Name (First, Middle, La	· .						First, Middl		Sumame)					
<u>a</u>	ould be Mental arked o	To E	Robert Olin So	rrells				Sue	nella	Thom	pson						
Maryland	and le ma		19a. Informant's Name/Relationshi	(Type, Print)	19b. Mail	ing Address	(Street	and Numbe	er or Rural i	Route Num	ber, City	or Town, State	Zip Code)				
≥	and ealth m 27		Charlotte E. S	orrells / Daught	er 3216 Place of Disp	Go1d	Mine					Maryla ocation - City	nd 20833				
0.0	Pages 1 nent of H nut: if Ite ury or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		cemetery, cre Gate Cen	matory or of OT Hea	ther plac IVen	(8)	March		110						
altimore,	tmen tent: tent:		4 Donation 5 Other (Spe			metery 2. Name an			200	6	511V	er Spr	ing, Maryland				
Ba	permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: if Item 27 Ie marked or any injury or other traumatic eve once.		21. Signature of Funeral Service U	wille, le, Mary	land 20950												
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the denty one cause on each line.	eath. Do not en	nter the <i>m</i> ode	e of dyin	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death				
	Physician		Immediate Cause (Final disease or condition	_a Lung Cand	cer								18 months				
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):												
Н	*	7	Sequentially list conditions,	b. Due to (or as a cons	wence of												
/	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):												
760,	ate be executed hysician and the burial-transit	call		d													
.89	uficat g phy as th	P							- mercin	N TO THE							
Вох	Attending Physician: The law requires that the death certificate be executed refath.  refath.  ector: After this certificate has been signed by the attending physician and be the funeral director, page 2 should be deteched for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prec		□Ectopic pr	egnancy	r				23d. Date of c					
B	deat ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time o		Other (sp						Month	Day Year				
о. О.	at the	Phy	9 🗆 Unknown							22a Die	l tabassa	use engleibute	to the cause of death?				
<u>က်</u>	res tha iigned be del	by	Part II. Other significant condition				ause giv	en in Parti.	•	_			Probably 4 DUnknown				
Records,	w requir been si should I	Completed	Idiopathic thro	ombocytopenia,	Purpur	a					-	ī					
ec	has b	npie								24a. Wa	is an opsy formed?	24b. Were prior t death	autopsy findings available completion of cause of				
<u> </u>	cate									1 ☐ Yes		1 T	es 2 No				
Division of Vital	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only							
o	Phys rthis raldi	- To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury	☐ ER/Outpatie		8c. Injur Wor	4 - 140				6 Other (Sp	oecity)				
O	ding th. After	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year,	) Injury	м		k? Yes 2 🔲	No								
<u>is</u>	or Attendated after death	fica	3 ☐ Suicide 6 ☐ Could no	ed 289. Place of Injury - A		treet, factory	, office		28	Bf. Location	(Street a	nd Number or	Rural Route Number,				
É	P # 5	Certification:	4 ☐ Ho <i>m</i> icide	building, etc. (Spe	ксту)					City of 1	own, Stat	θ)					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page			Physician: To the best of my k													
	the H in 24 the F	Medical	one)	and manner stated.													
	To To To To	Z	29b. Signature and title of certifier	1		290		5880					nth, Day, Year)				
)	7	1	- Jolle	Jul			D4.	7000			Ma	arch 27	, 4000				
	10			ho completed cause of death (I			1	111.	Ma	lond	2001	50					
			Leon Hwang, M	D. 1396 Picca		ve, KC	CKV	ттте,	пагу	тапа	2085	00					
	Sta Regist			16 Assertation	Soca Contraction of the Contract	20											
			IN B D THM	JU RANGELER AS	100	-											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 25, 2006 1:00 PM M Edith G. Sita /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Anna Arundel Medical Center</u> 1 Uenter Annapolis
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. <u>Anna Arundel</u> 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2XF Yrs Director 218-24-1006 November 5, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow r than "natural", or items 23a or 28e-f ehov The Madical Examinar mant ke putified at 1 ☐ Yes 2 X No Director Davidsonville Maryland Anna Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3697 Nile Road 21035 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental ie marked Ella Ray Thompson Arthur Walton Matthews 19a. Informant's Name/Relationship (T, pe, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Geraldine R. Mady/ Daughter 3697 Nile Road Davidsonville, Maryland 21035 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
importent: if its
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)Entombment of Heaven Mausoleum 31, 2006 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fuperal Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolism **Physician** ulmonary > 2day /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tailure 1 ☐ Yes 2 ☐ No 3 Probably 4 🖼 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 10 certificete 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nopatient ို 1 ☐ Yes 2 ☐ ★ 2 ER/Outpatient 3 DOA Lis After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I PC Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier

Registrar DHMH 17 Rev 1/2001

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State

29b. Signature and title of pertifier,

31. Date filed (Month, Day, Year)

MAR 2 9 2006

wyort

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reterson

MD

32 Registrar's Signature

29c. License number

AMC

124804

29d. Date signed (Month, Day, Year) 03-25-2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year DOROTHY  $\mathbf{E}$ SHEFFEY March 27 2006 1:50a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON HEALTH & REHAB CNTR-PIKESVIILE PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 215-16-9228 84 MAY 17 1921 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show The Medical Examiner must be notified at 1 □XYes 2 □ No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3926 CLARINTH RD Completed by Funeral 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XX ever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTH CARE 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental I BOYD SHEFFEY BARBARA LUSTER and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Beverly E. Brooks/Daughter 3926 Clarinth Rd., Baltimore, Maryland 21215 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 03-28-06 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE arbara 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jasoula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Arterioschadic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parlure chanic rend 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed insufficience astery 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No Vital 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ≥ No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after death Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles Street KRFaulkner MD 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar MAR 2 9 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 17 2006ar Tanis Scott 1826 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 59 Yrs. 216-44-6255 Director Jan 4 1947 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Anne Arundel Annapolis X Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 925 Central St. 21401 USA death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1964-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXVo þ Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Assembler Martin-Marietta 12th permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: if Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James A. Scott Lola C. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Scott(Wife) 925 Central St. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 3-24-06 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Jan 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia ntardiou **Physician** Commediale /Medical Examiner ev 1en 5104 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or ast Examiner consequence of): burial-transit The law requires that the death certificate be executed Desi physician and Due to (or as a consequence g Box 68760. Physician/Medical use as the attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year signed by the at id be detached for 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospitel or Attending Physicien: I within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 100 ို 2 ER/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day) 27. Manner of Peath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1017965 8/06 Tense 21401 31. Date filed (Month, Day, Year) State MAR 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Taylor Elmer William /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 Months Days Hours Min. 1 1 1 04 Year) 23 5. Social Security Number Birthplace (State or Foreign County) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months **½** 2□ F 82 Yrs. Director 218-12-3597 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

I Hygiene.

Ther than "natural", or Itema 23a or 28a-f ahow vant, the Medical Examinar matter colling at Vant, the Medical Examinar matter colling at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. Completed by Funeral 5925 Ayleshire Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ¥¥Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A& P Food Market permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: if Item 27 is marked other II any injury or other traumatic avant, IIM ODG. 8th grade na Warehouseman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Thomas E. Taylor Willie B. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5925 Ayleshire Road, Baltimore, Md 21229 Ernest Taylor-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 3/30/06 Arbutus, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lines. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a confequence of) physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 📮 No 1 Yes 2 1 No or Attanding Physician: After this certific funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur and title of certifier 29c. License number 31. Date filed (Month 32. Régistrar's Signatura State 2006 9 THE SECOND Registrar

			1 - For State Registrar	State of Maryla			nt of Heate of De		Menta		ene	5	096	08
	Physici /Medio		1. Decedent's Name (First, Middle, Last, RicHard	VEBEL					, Mc	te of Death onth	Day 21	Year 2000	3. Time of	Death A-M
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	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-1 show ta Medical Exant na must be notified at	ctor	10a. State 10b. County MD		City, Town altim								10d. Inside C	ity Limits 2 No
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Mar	12 sh h and 7 fs rr traur		19a. Informant's Name/Relationship (T) Donna Moxley/frier					NumberorA e Driv				wn, State, Zip Code) MD 21060		
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Macical Examinating the notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	20th	D. Place of D	Disposition (N. crematory of	ame of		Date	-		on - City or T		
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O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of predictions of the second of the s	etal death	3□Ectopic 5□ Other (				23d. Date of de Month			,	Year
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Divisi	at or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farr ecify)	n, street, facto	ory, office		28f. Lo	cation (Stre by or Town,	et and Nu State)	mber or Run	al Route Num	nber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phy one) 1 Medical Exami	sician: To the best of my liner: On the basis of exam and manner stated.	cnowledge, ination and	death occurre for investigation	d at the time, on, in my opini	date and place ion, death occ	ce, and du curred at th	e to the cau ne time, date	se(s) and e and plac	manner as see, and due t	stated. to the cause(s	5)
	To t To t	¥	29b. Signature and title of certifier	4		2	9c. License n					ned (Month,		
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			30. Name and address of person who co	ompleted cause of death (I	_	ype, Print)		Ca	- 1	Ω		, ,,,,	2000	I
		10	31. Date filed (Month, Day, Year)	Registrar's Sig	2000	Gne	خلخ	STR	+33	( Da)	Hmen	ic, M	22 y/Aux	ځ
8	Sta Registi		MAR 2 9 200	S Comment	C. A.	AB46								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 3 4:50 Am Lois Mae Vaught 2006 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore quare nosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10, 1926 5. Social Security Number Birthplace (State or Foreign Country) (In yrs. lest birthday) **Funeral** Days Hours 1□ M 2□F Yrs Director 225-22-2296 79 June Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits an "naturel", or frems 23s or 28s-f sho Medical Examiner must be notified at Maryland Baltimore Middle River Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 612 Lanoitan Road, 21220 Apartment E U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Yes ♣♠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: White δ 302Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within 72 i Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should 2 |Walter Ray Sult Mable Lewellyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3439 McShane Way, Baltimore, Maryland 21222 William Vaught (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/30/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 at the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has Medical Certification: To

or Attending Physician: The law raquiras that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. s aftar deam.

al Director: After the by the funer. completaly fillad in by To the Hospital within 24 hours a To the Funeral L

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9h Signature and	title of certifier				1 2	9c. License numb	her	294	Date signed	(Month Day V	eer)				

D63639

March 27th 2006

Franklin Square Drive Balto, Mb. 21237

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 2 9 9 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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PATRICIA AFORICA31. Date liled (Month, Day, Year)
32 State MAR 2 9 2006 Registrar

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

OCME

MARCH 28, 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 19, 4:52 AM M March 2006 Margaret Virginia Wayland /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Middle River 1340 Burke Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2₩F 83 Yrs. Dec 25, Virginia Director 212-20-8334 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other then "neturel", or Items 23s or 28s-f show event, the Medical Executer must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 1340 Burke Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ther any injury or other traumatic event. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 0 housewife own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Joseph Reed Annie Daisy Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 Burke Road Baltimore, MD 21221 Paul Breeden/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald e Licensee S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 March 1 MD 21201

mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, delle Approximate Interval Between Onset and Death Ta. Part. Enter the disease, or amplications that caused the shock or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician 4 years /Medical resulting in death) Due to (or as a consequence of): Examiner Hoberia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit ensentia and Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à þe 1 Yes 2 No 3 Probably 4 Unknown Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 page 2 🗆 No 1 ☐ Yes 2 No 1 Tyes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one. examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Alter Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 1 within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 a 32 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar MAR 2 9 2006

DHMH 17 Rev 1/2001

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	Physici		Decedent's Name (First, Middle, Last)     KENNETH LUTHER	WILLIS  2. Date of D Month MARC	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	LAGITIII		26 SOUTH CHURCH ST.	WESTMINSTER	CARROLL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		irth 9. Birthplace (State or Foreign
	Director		215-34-2373 15 M 2 F 67 Yrs.	12/19	/1938 MARYLAND
	pu 💃		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation	10d. Inside City Limits
	ehov	7	MD CARROLL WESTMI		1X Yes 2 ☐ No
	the M	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other than "natural", or itema 23a or 28a-f ehow event, the Madical Exeminar must be notified at	古	26 SOUTH CHURCH ST.	21157	USA
	na 23	Funeral			
	r Ren	F	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
e e	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	Specify: BLACK
5-0036	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b. Kind of Business/Industry
2	within 72 ene. than "na!	nple	Elementary/Secondary (0-12)   College (1-4or 5+)	s kind of work done during most of working DO NOT use retired)	
2	filed with Hygien of ther the	Co		MAINTENANCE	EDUCATION
ב	be fil d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
<u> </u>	should be nd Mental marked o	ဥ	HERBERT WILLIS, SR.	GENEVIEVE	HAMMOND
Maryland	C/ G = 9			ing Address (Street and Number or Rural Route Route Number or Rural Route Ro	
	1 and Health em 27		20h Bloom of Disease	S. CHURCH ST., WESTM	20c. Location - City or Town, State
و	Pages ment of ant: If it ury or o		12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  MEADOW BR	matory or other place) ANCH CEM. 4/1/06	WESTMINSTER, MD.
altimore,	it. Partition		21. Signature of Funeral Service, Licensee 2	2. Name and Address of Facility FLETCHER	
Ba	permit. Page Depertment o Importent: If any injury or once.		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	54 E. MAIN ST., WESTM	
		1	23a. Part1. Enter the disease or complication that caused the death. Do not en		
	Physician	. 3	Immediate Cause (Final	CANCER	Onset and Death
1	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	CANCETC	
П	Examiner				
Ļ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
1	cuted nd ransi	Examiner	that initiated events C.		
Š	be executed sicien and burial-transit	Ä	resulting in death) Last Due to (or as a consequence of):		
8760	# × 5	lcal	d		
×	leath certifica attending ph i for use as th	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
Box	atter for u	lan	in the past 12 months?	Ectopic pregnancy	23d. Date of delivery  Month Day Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown	Other (specify)	
1	The law requires that the site has been signed by those 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Vital Records,	uires sign ld be	d by		1 🗆	Yes 2 No 3 Probably 4 Inknown
Ö	w require been sis	ete		24a. Wa	s an 24b. Were autopsy findings available
Re	nysician: The law nis certificete has I I director, page 2 s	Completed		per	prior to completion of cause of death?
ta	Inficet tificet for, pa	0	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only	
	yalci is cer direct	To B	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor	
<u></u>	= = =		27. Manner of Death  1. Description 28a. Date of Injury (Month, Day Year) Injury		how injury occurred
Ö	uttending P death. ctor: After y the funera	atlo	2 Accident investigation	M 1 Yes 2 No	
Division of	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	itel or rai Dire lled in t				
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check cylly one) 2 Medical Examiner: On the basis of examination and/or in and many proper stated.	h occurred at the time, date and place, and due to the ivestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
	thin 2 the mplei	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
١	8 18 1		Hall Day Ver MD		
7	. 0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print	5,00
	10		FlAVIO Mutar md 355 South	D3539& Caxa Street Wishin	WHO MU SIIST
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registr	ar	MAR 2 0 2006 Real As	2000	

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📋 📋 🗧 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 14:37 MARCH Sylvia Elaine Wagner 4a. Sacility Name (If not institution, give street and number) 4c. County of Death 4b. Gity, Town, or Location of Death BALTIMORI HONES HOSPITAL N/A141101 Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 7. 1926 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Hours Months Days 1□M 2\ F 80 217-22-4660 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ∑Yes 2 ☐ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2028 Grinnalds Avenue 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Cutter Garment 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Howard Siegle May Nizer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 19a. Informant's Name/Relationship (Type, Print) 6405 Centennial Circle, Apt. A. Glen Burnie, MD William L. Siegle Brother 20b. Place of Disposition (Name of cerpetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3-30-2006 Baltimore, MD 4 □ Donation A □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Fun-ral Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmonary Chronic Advanced Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bronchitis 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner Examiner burial-transit and Completed by Physician/Medical phys. use as

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**Physician** 

/Medical

Examiner

Directo

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Completed

Be

**Funeral** 

Director

J. Hygiene. other than "natural", or items 23a or 28e-f ehow vent, Ite Madical Examinational be notified at

death

filed within 72 hours after

. Pages 1 and 2 should be fill ment of Health and Mental H tent: if item 27 is marked ott jury or other treumatic even

Department of Importent: If any injury or once.

**Physician** 

Baltimore, Maryland 21215-0036

certificate After this certific funeral director. this the e Director

Be ို Certification: Medicai

death. nours after within 24 hours aft To the Funeral Di completely filled in

Michille Henggeler 31. Date liled (Month, Day, Year) State Registrar

1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)



MAR 2 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 FR/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

28c. Injury at Work?

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

D0053312

Bultimore MD 2/229

28d. Describe how injury occurred

28l. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 26, 2006

_			For State Registrar			State o	f Mai	ryland				lealth a		1ental ⊦	lygie Reg.	C U U	6	09615	
	Physicia /Medic		1. Decedent's Nam Wilbur C			ner I	II							2. Date of Month March		Day 2006	Yeer	3. Time of Death 6:50 a <sub>M</sub>	ı
	Examin	er	4a. Facility Name ( Joseph R	If not institution	n, give str Hosp	eet and nur Dice	nber)			4b. City, Balt		Location o	of Death			4c. County N/A	of Death		
Ī	Funeral Director		5. Social Security N 214-38-17	87	6. Sex 1 🔯 N	/ 2□F	-	(In yrs. Ia 64	st birthday) Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of June	Birth Ye 26,	<sup>ar</sup> 1940	9. Birthp Cour Mary	place (State or Foreign Tand	7
	Maryland -fehow	tor	Usuel Residence of 10a. State MD	10b. County Balti			1	10c. City, Arbut	Town or Lo	ocation								10d. Inside City Limits	
	3a or 28a	i Direc	10e. Street and Nu 5000 D We		Blvc	l				10f. Zip						Citizen of V	Vhat Cou	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland pepartment of Health and Mantal Hygiene. Important: if item 27 is marked other then "natural", or Itema 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Mari 3 □ Widowed	_	bei	Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2 <del>□</del> No			Was Dece If Yes, spe		ispanic Ori an, Mexican Specify:		ecify Yes or Rican, etc.)	No-	Blac	e - Americk, White, ,.white,		
21215-0036	within 72 ho iene. then "natur	Completed	(Spec Elementary/Seco 12	15. Deceden cify only highe ondary (0-12)	t's Educa st grade o	tion completed) College (1	l-4or 5+		16a Dece (Give life. Securi	kind of wo DO NOT u	ork done i se retired	ation during mos	st of work.	ing		ecuri		dustry	
	uld be filed Aental Hyg rked other tic event,	0	17. Father's Name Wilbur C.			Jr.								e (First, Mid • Gore		den Suman	7e)		
ਨ Mary	and 2 sho valth and N 27 is ma		19a. Informant's N Rhett W.							-				a <i>i Route Nu</i> n Ohio			State, Zip	Code)	
(A3 (O C Baltimore, Maryland	Pages 1 ament of He ant: if iten ury or oth		20a. Method of Dis 1 ♣ Burial 2 4 ♠ Qonation	Cremation		moval from	State	Ce	ace of Dispo metery, crei d Shep	matory or o	other plac	etery		Date 7 <b>-</b> 2006	1	Location -			
	permit. Departimport. any inj		21. Signature of Fi	1000	4	som	alle	of	F	mbro	se Fi	hiir S	1 Ho	me, Ir g Rd.	Arh	utus_l	1D 21		
Jer 3	Physician Physician and Medical Examiner physician and physician and the pritian-transit	ıi Examiner	23a. Pan1. Enter shock, or hea immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undicause (Disease or that initiated event resulting in death)	(Final on onditions, mmediate aritying injury s	complicationly one	Due to	(or as a	conseque	ence of):	er the mod	de of dyin	g, such as	Gardiac o	or respirator	y arrest,	net	3	Approximate Interval Between Onset and Death	
JOERN P.O. Box 687	thet the death certific od by the attending p detached for use as	/ Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr Part II. Other signi	? months? □ No		ilf yes, out 1□Live b 4□Pregn 9□ Unkno	oirth 2 nant at ti own	Fetal ( ime of de	death 3[ ath 5[	□Ectopic p □ Other (s)	pecify)		i.	23e. D	id tobac	Мо	te of deliventh	ery Day Year	
Aecords.	w requires to been signer should be	leted by							-					1 24a. W	:			pably 4 Monknown	
John Wital Re	ician: The lav certilicate has rector, page 2	e Completed	25. Was case refe	rred la medica	1				-			36 Bloom	o of Door	a	utopsy erformed s 2/1	1?	prior to co death?	mpletion of cause of	-
JI ()	ding Phys T. After this funeral di	ToB	examiner? 1 Yes 2  27. Manner of Dea 1 Natural 2 Accident	No th 5 ☐ Pendir investi	Ho ng gation	spital: 1 🔲 I 28a. Date (Mon	Inpatient of Injury th, Day		ER/Outpatier 28b. Time o Injury		28c. Injur Wor	er: 4 □ Ni	ursing Ho	ome 5 R	esidenc	injury occur	red	Herpice	ン
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 4 Homicide	6 Could determ	ined	buildi	ng, etc.	(Specify)						City or	Town, S	State)		al Route Number,	
	the Hospital thin 24 hours a the Funeral mpletely filled	Medical	29a. Certifier (Check only one)  29b. Signature and		Examine	er: On the b	asis of e	examinati	vledge, deat on and/or in	vestigation	n, in my a	me, date ar ppinion, dea se number	nd place, ath occur	and due to red at the tir	ne, date	e(s) and ma and place, Date signe	and due t	o the cause(s)	
	To To corr		30. Name and add	u Plin	ull	MI poleted caus	se of des	ath (Item	23a) (Tung		72	30/	2	- /		3/2	3/11	6	
	Sta	te.	30. Name and add	Wy	Tyn	C	43	r's Signati	Inda	rule	W.	RA	1	BOHO		Mal	2/	218	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Whitelock Month Year **Physician** Herbert Mar 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens of Columbia Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day, Year) MR 4 1929 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 77 Yrs. 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Indiana Director 315-24-8933 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Iteme 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 No Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with 10758 Autumn Splendor Drive 21044 **USA** Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Mayes 2 □ No If Yes, Give Year or Dates: 52-54 Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced white "natural", Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Goddard Space Elementary/Secondary (0-12) College (1-4or 5+) Flight Center Systems Engineer 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Hooker В. Whitelock Anna Bessie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10758 Autumn Splendor Drive, Columbia, MD Nancy R. Whitelock - wife 21044 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/28/2006 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses CAFA, Stephen D. Lohrmann, PA M00986 8717 Green Pastures Drive, Towson, MD Thele 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Driset and Death Immediate Cause (Final disease or condition resulting in death) Parkinson's Physician 6 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of). Examiner physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical attending ph NIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death NIA 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☑ Inknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s hes certificate 1 ☐ Yes 2 No the funeral director. 25. Was case referred to medical examiner? Be Assisted 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death 3 ☐ Suicide 6 ☐ Could not be To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicul Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56531 March 27,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hickory Riage Rd, Columbia, MD 21044 Lij M.D. 10780 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2006 Registrar

ADH WILLIAN 06-2**1**08

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

M WHARTO 8	N	Please	Type or Prin							ole.		
	1 - State Registrer			-	•		f Health and of Death		Reg. No.	5	096	17
Physician /Medical	1. Decedent's Nam William	me (First, Middle, La Wharton	st)					2. Date of Dea Month MARCH	ath 26, 2006	Year O	3. Time of 0735	Death A <sup>M</sup>
Examiner		(If not institution, giv OLIVER S'	re street and number)		4	4b. City, Tow BALTT	m, or Location of Deat		4c. County			
Funeral Director	5. Social Security 220-38-	Number 6.5		63		If Under 1 Y			h 5/1943	9. Birthpla Count	ace (State of	r Foreign
how dell	Usual Residence	10b. County		10c. City, Town		tion				10	Od. Inside Cit	
arier bearn with the maryland or iteme 23a or 28e-f show chinar mast & notified at Funeral Director	MD 10e. Street and N	Baltimo	ore	Dundal	L.k	10f. Zip Co	de		10g. Citizen of W	hat Count	1 Yes	2   No
e 23a or mat ke rai Di		Oliver St					21205		United			
el', or item Examiner n by Fune	3 ☐ Widowed	rried 2 Married 4 Divorced	12. Was Decedent I Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			s Decedent 'es, specify (	of Hispanic Origin? (S Cuban, Mexican, Puerl No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)		· America c, White, e <b>Whi</b> t	itc.	
ygiane. her than "naturel", it, tre Medical Ex. Completed by	(Special Special Speci	15. Decedent's E- ecify only highest gra condary (0-12)	ducation ade completed) College (1-4or 5	+)	(Give kir	NOT use re	one during most of wor	rking	16b. Kind of Bus Sheet M		ustry	
Mental Hygiane.  arked other than "naturel", astic event, tha Medical Exa  To Be Completed by	17. Father's Name	(First, Middle, Last, Wharton	)				18. Mother's Nar	ne (First, Middle, Gregor	Maiden Sumame	9)		
alth and h	19a. Informant's h	Name/Relationship ( Clark/Daugh		28	809	Gray N	eet and Number or Ru fanor Terra					
portine. To such a such a predict of the such and Manial Hygiane. Important: If I fem 27 is marked other than "na any injury or other freumatic event, the Mediano.  To Be Complete.	4 Donation			20b. Place of cemeters Chesay	peak	e Crem	place) natory Inc.		20c. Location - ( Beltsvil	•		ıd
g physicien and strength as the burial-transit and language as the burial-transit and language a	23a. Part1. Enter shock, or he Immediate Cause disease or conditions are seen to be a seen to be	onditions, minediane letrying r injury ts	b. Due to for as a	10.	ot enter i	the mode of	en Pastures dying, such as cardiad otic Cava	or respiratory are	rest,		Approximate Interval Betw Onset and D	veen
the death.  Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the bush the funeral director, page 2 should be detached for use as the bush the funeral director.  To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months? □No	23c. If yes, outcome of the little of the l	2 Fetal death		ctopic pregna other (specify			23d. Date Mon	of deliver	· .	'ear
been signed be should be deta	Part II. Other sign	ificant conditions o	contributing to death bu	ut not resulting in	the unde	erlying cause	given in Part I.		bacco use contri es 2 \( \subseteq \text{No} \)	bute to the	11	eath?
certificate has been silrector, page 2 should						-		24a. Was a autops perfor 1  Yes	sy pr megl? de	ere autopo for to com eath? Yes 2	sy findings a pletion of ca 2□ No	vailable use of
r this certifice ral director, p	25. Was case reference examiner?  1) Yes 2		Hospital: 1 ☐ Inpatier	nt 2□ER/Out	patient	3□ DOA	Other	ath <i>Check only or</i> lome 5 ☐ Reside		r (Specify)	SCENE	
ath. or: After th ne funeral ation: T	27. Manner of Dea 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injur (Month, Day	y 28b. Ti		28c. I	njury at Work?		ow injury occurre			
within 24 hours after death. To the Funerel Director: After completely filled in by the funer.  Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, far . (Specify)	m, street	, factory, off	се	28f. Location (Si City or Town	treet and Numbe n, State)	r or Rural	Route Numb	oer,
thin 24 hour o the Funerampletely fille	29a. Certifier (Check only one)	1☐ Certifying Ph 2☑ Medical Exam	ysician: To the best on niner: On the basis of and manner states	examination and	death or	ccurred at th	e time, date and place by opinion, death occu	, and due to the c rred at the time, d	ause(s) and man late and place, a	ner as sta nd due to t	ited. the cause(s)	
To the comp	29b. Signature and	d title of certifier	1			29c. Lic	ense number	2	9d. Date signed	(Month, D	ay, Year)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COUCH, AUA W 111 ]

31. Date filed (Month, Day, Year) | 32 Registrar's Signature



111 PENN STREET, BALTIMORE, MARYLAND, 21201

OCME

27, 2006

MARCH

			1 - For State Registrar	State of Ma		artment of H tificate of L		lental Hygier	4000	09618
	Division		1. Decedent's Name (First, Middle, Last)						Day Year	3. Time of Death
	Physici /Medic				LURST			-	5 2006	
}	Examin	er	4a. Facility Name (If not institution, give s		7	-	Location of Death		4c. County of Deat	FORD
			472 SEDGE / 5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	EWOO	8 Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director			M 2K)F	63 Yrs.	Months Days	Hours Min.	(Month, Day, Yes	ar) Co	untry) IRGINIA
			Usual Residence of Decedent							
	show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ba-f.	Director	MARYLAND HARFORD	CO	EDG:	EWOOD		10-	Citizen of What Co	
	with th		10e. Street and Number			10f. Zip Code	40	log.	U.S.A.	untry :
	eath vs 23	era	472 SEDGEMORE COU:	R'I' 12. Was Decedent E	ver in U.S. 13. \	210 Was Decedent of H		ecify Yes or No-	14. Race - Ame	nican Indian,
10	r Iten	Funeral	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐Mo	,	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
9	ral', o	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2ŪXNo ————————————————————————————————————	Specify:		Specify: BL	ACK
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show he Madical Examiter roust be codified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing 16b	Kind of Business	Industry
7	within ane. then	d L	Elementary/Secondary (0-12)	College (1-4or 5+	)	URSES ASS	,		HEALTH C	ARE.
0 7	Hygie The		12th grade   17. Father's Name (First, Middle, Last)		IN	UKSES ASS		e (First, Middle, Maid		711(1)
an	id be lental ked c	To Be	RALPH JONES SR.				ETHEL	H SMITH		
Maryland	shou and M mar		19a. Informant's Name/Relationship (Ty	pe, Print)				al Route Number, Cit		Zip Code)
	end 2 salth in 27 I		Roosevelt Whitehu	rst/Husbar				gewood, Mo		
ore	of Heror		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ P	emoval from State		natory or other plac	(8)		Location - City or	
텵	then then tant:		4 □Donation 5 □Other (Specify)	1	MOYOCK C			01-06 MC	YOCK, NOR	TH CAROLINA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Itema 23a or 28a-f show amortant: in litem 27 ie marked other then "natural", or Itema 23a or 28a-f show amortant: in Item Madical Experiment of the madical Experiment of the madical Experiment of the madical Experiment of the madical Experiment.		21. Signature of Funeral Service Users	3	W 3	2. Name and Addres M C BROWN 21 S PHII	ss of Facility I COMMUNI LADELPHIA	TY FUNERAL BLVD., AE	HOME-HA	RFORD P.A. MD 21001
	_		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each line	he death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Opset and Death
Ì	Physician		Immediate Cause (Final disease or condition	ASCU						Years
	/Medical Examiner		resulting in death)		consequence of):					. 1
П		PF	Sequentially list conditions,	Dua to for an a	equaednauca ng).					Years
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes						Years
ó	te be executed ysicien and ie burial-transit	Exa	resulting in death) Last		consequence of):					
8760,		Ical		j						
9	entifica ling pt e as t	Med	IF FEMALE:	i2a If was autaama a	f oragonous					
Box	death certifica e attending ph id for use as th	Physician/Med	in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t	Petal death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
P.O.	0 0 0	ysk	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9☐ Unknown						
	The law requires that the ate has been signed by the bage 2 should be detache	by Pt	Part II. Dther significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	quire an sig	ed b	Dysphasia					1 ☐ Yes	2 No 3 □ P	robably 4 Unknown
000	aw re as be	Completed	Aug tamis					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ď	The ate h	Com						performed 1 ☐ Yes 2 🗖		2 No
/ita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Jacoutal:		Oth		th (Check only one)		
of	Phys this aldi	٠ <u>۲</u>	1 ☐ Yes 2 No  27. Manner of Death		t 2 ER/Outpatier		4 🗀 Nutsing H	ome 5 Residence 28d. Describe how in		icify)
Division of Vital	After fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Wor	k? Yes 2 □ No		.,,	
<u> </u>	or Attending after death. Director: After I in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm, str	reet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
ā	s after s after s Dir	Cert	TIOINCIDE	building, etc.	(эрөспу)			Only of Town, O		
	To the Hospital or Attsnowithin 24 hours after deatly to the Funeral Director: completely filled in by the	dical			examination and/or in			and due to the cause red at the time, date		
	within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)
)	A		Gland Kleen	Mo		D 31.	295		3/27/06	
	V	1	30. Name and address of person was co	ompleted cause of de	ath (Item 23a) (Type,			51. 100	1 2	M. 2,220
			31. Date filed (Month, Day, Year)	5601 Lo	CH KAUE	NULVO	, P.U.B.	, ste aud	M, DALT	, Mo 21239
	Sta Regist	ate rar	MAR 2 9 20	197.		we				
Di	IMH 17 Rev 1/2		MAR & 3 ZU	OO   MARKET	1					

			1 - For State Registrar	State of N	Maryland /		artment rtificate			and Me		giene	MAG	096	519
	Physici /Medic Examir	al	Decedent's Name (First, Midd     James William     4a. Facility Name (If not institution)	Zimmerman	er)		4b. City, 1	Fown, or	Location o	М	2 Date of Dea Month arch 2	Day 7 <b>,</b> 2	Year 2006 County of Dea	10:1	of Death  O A
ें. इस	Funeral Director	. 8	Kline Hospice 5. Social Security Number 218–40–2711		Age (In yrs. last b	oirthday) Yrs.	Mt A If Under Months		If Under a	Min.	3. Date of Birth (Month, Day Aug • 14	h Z Yearl	. C		te or Foreign
	ath with the Maryland 23a or 28e-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Fred  10e. Street and Number	erick	10c. City, To Frede		τ	Codo				10- 6	izen of What C	1. <b>X</b>	City Limits
	hours after Jeath with the Maryland tural; or items 23a or 28e-f ehow at Exercipat mast be notified at	Funeral Dir	104 West Nint	12. Was Deceder	s?	13.	Was Deced	2170	J.S.A.  14. Race - Ame Black, Whi	erican Indian					
9500-612	swithin 72 hours affiliene. Jiene. Ir then "netural", or Ir e McJicel Exerri	Completed by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	1 Yes 2 dent's Usua kind of won DO NOT us	l Occupa	lurina most	Specify: W							
7 0	be filed htal Hyg ad othe svent,	To Be Com	College (1-4or5+)   College (1-4or5+)   Truck Driver   Construction												
re, mary	s 1 and 2 should f Health and Men from 27 is marke other treumatic		19a. Informant's Name/Relations Mrs. Vickie M. 20a. Method of Disposition	Zimmerman,	wife	104 of Dispo	West	Nint	h St	or or Rural	Rou <i>te Numbe.</i> edericl	r, City o	Town, State, 10 21701	L	
Baitimore,	pernit. Pages Department of Important: if it any injury or o		Burial 2 Cremation 4 Donation 5 Other (S  21. Signature of Funeral Service	Specify) Licensee	Mount Mount	22	2. Name and	d Addres	s of Facility	Keene	ey and	Bas	derick ford Fu	neral	Home
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each	in Metas	tas:	er the mode						IICK, M	Approxir Interval	nate Between nd Death
on,	ate be executed whysicien and hysicien and the burial-transit and	dical Examiner	Esquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Non- Due to (or a	as a consequence as a consequence as a consequence	ell e of):	Cance	er o	f Lun	g				18 mc	nths
Ď.	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal deat at time of death		Ectopic pre Other (spe						23d. Date of de Month	livery Day	Year
cords, P	w requires that the been signed by th should be detache	ompleted by Ph	Part II. Other significant condition Chronic Obstruction					iuse give	n in Part I.			es 2(	No 3 P	robably 4	□Unknown
VII Aecord	ysician: The law r iis certificate has be director, page 2 sh	Be C	25. Was case referred to medica examiner?	Hospital:				Otho			autops perform 1 Yes Check only or	sy med? 28 No 18)	death?	completion of	d cause of
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death as a fine death for the Funerel Director: Attent his certified completely filled in by the funeral director;	ertification: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could	28a. Date of Ir (Month, L	Day Year)	Time of Injury	M 28	Sc. Injury Work	" 4 □ Nur at ? 'es 2 □ N	10 28	d. Describe h	ow injur			
20	lospital or At hours after of unerel Direct sly filled in by	edical Certif	4 Homicide determ  29a. Certifier 1 X Certifyin	nined 286. Place of I	Injury - At home, in etc. (Specify)  st of my knowledge of examination a	ne. death	occurred a	it the tim	e, date and	d place, an	City or Town	n, State	and manner as	s stated	
	o the l	Medi	one) 29b. Signature and title of certifie	and manner	stated.	0, 111			number				e signed (Mont		
	⊢≯⊢ó			2	va.	ne	ות	.4626	5				27, 20		
	1,3		30. Name and address of person	who completed cause of	death (Item 23a)	) (Type,	Print)			d *					
黎	Sta Registr		P. Gregory Raus 31. Date filed (Month, Day, Year)		strar's Signature				, rre	ueric	K, Mar	yıar	id 21/0	ŊΙ	

			For State Registrar	State of Ma	arylan	•	rtmen			and M		jiene	6	09620
	Physici	an	1. Decedent's Name (First, Middle,				4				2. Date of Dea Month	Day	Year	3. Time of Death
,	/Medic	al	Luther 4a. Facility Name (If not institution,	E.	As	shenfel		Town or	Location of	of Death	03-2	4c. County	Of Death	9:15 PM
	Examin	er	56 Boone Street					berl		, Deali		Alleg		
	Funeral Director		234-42-9397		e (In yrs. i 76	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	1929	9. Birth Cou	place (State or Foreign
	Aaryland I show	ō	Usual Residence of Decedent  10a. State 10b. County  MD Alleg	any	10c. City	, Town or Loc Cumb	erlan	d		,	<u> </u>			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the N	Funeral Director	10e. Street and Number 56 Boone Street				10f. Zip		21502	2		10g. Citizen of	What Cou	ntry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23a or 28a-f show svent, the Mudical Extrumer must be notified at	5	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d NYes 2 1 If Yes, Give Year or Dates:			Vas Deced Yes, spec	X	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		ce - Americk, White	
Maryland 21215-0036	within 72 ho iene. then *naturi ite im vicel i	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		i+)	16a. Deced (Give life. L Store	kind of wor DO NOT us	k done d e retired	ition Juring mos )	t of work	ng ·	16b. Kind of E		,
land ?	should be filed within of Mental Hygiene. marked other then imatic event, the matter event, the matter event, the matter event.	To Be C	17. Father's Name (First, Middle, La Cleal Ashenfe						18. Mothe	ar's Name	(First, Middle, 1ae (Rol	Maiden Suma Dinette)	Ash	enfelter
	s 1 and 2 should of Heelth and Men item 27 is marke other traumatic		19a Informant's Name/Relationshi Shelby Morgart	p (Type, Print) niece	)	19b Mailin 125	Highl	(Street a	Drive	er or Rura	Ridge	eley	, State. Z	V°26753
Baltimore,	Page ment c ant: if ury or		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spe		Sur	lace of Dispo emetery, cren ISET WIEN	sition (Nar. natory of P nonal I	ne of ther place ark	θ)		3/25/2006	Cumb		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Li	The	W		10	8 Virg	inia A	venue	ome, PA e: Cumbe		2150	
	Physician /Medical Examiner		23a. Party Eyler the disease, or of the shock, othern failure. List of immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ne. HST	ATIC		-	g, such as		CAN C			Approximate Interval Between Onset and Death
\ \ `		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b										
38760,	icate be e physicier s the buri	dical		d					•	1				
P.O. Box 6	that the death certificate be executed the by the ettending physicien and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No • 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pi Other (sp				-115		ate of deli	very Day Year
	sign d be	þ	Part II. Other significant condition	s contributing to death by CA12D16				ause give	en in Part I		23e. Did t		atribute to	the cause of death?
Reco	The law requive hes been bage 2 should	Completed									24a. Was auto perio 1 🗆 Yes	an 24b osy med? 2 No	Were au prior to death?	topsy findings available completion of cause of
ii a	ician: Th certificete rector, paç	Bec	25. Was case referred to medical examiner?							e of Deat	h (Check only o			
n of \	Attending Physician: " death. sector: After this certifice by the funeral director, i	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 Inpation		ER/Outpatien 28b. Time of Injury	1 2	8c. Injun Worl	/ at k?		ome 5 Resi			erfy)
Division of Vital Records,	or Attend after death Director: /	Certification:	2 Accident investigation of Could not determine a large determine	ot be 200 Place of In	jury - At h lc. <i>(Specil</i>	ome, farm, str	M reet, factor		Yes 2	INO	28f. Location ( City or To		nber or Ru	ral Route Number.
_	To the Hospitel or Attanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ledical Co		Physician: To the best examiner: On the basis of and manner st	of examina									
)	To th within To th compl	Me	29b. Signature and title of certifier	Pitysi	CIAN	J	29	c. Licens	o number	84	4	29d. Date sign	B/Z	n, Day, Year) 2   2006
	10			SOLUTION TO COLUMN	FRIA	MD	Print)	112	SFTO	N DI	rive a	moer	AUD	2/2006 , MDZ1502
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. egist	rar's Signa	15 A								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lillian Markley Ashley Year March 5, 2006 1:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 10, 1 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Months Days Hours Min Yrs. Virginia Director 1914 218-38-9272 Usuat Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-1 shov tre Medical Examiner must be notified at Silver Spring Maryland Montgomery 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 309 Williamsburg Drive 20901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any injury or other traumatic event, tre Medical Examina once. 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ 3 → Widowed 4 Divorced Specify Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County School Careteria Manager Food Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Cornelia Rupert Be Nathan Markley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Larch Ave. Takoma Park, MD 20912 Kathryn Marks - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/22/06 Arlington National Cem. Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Desys, S DAY neuman /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year ned by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 22 No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Oulpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? al or Attending F s after death. Certification: 28d. Describe how injury occurred Director; After 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47660 7.06 0 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Doinder Singh, M.D. ogistrar's Signature 31. Date filed (Month, Day, Year) State 1 4 2006 Registrar

5. Social Security Number

086-34-1274

10e. Street and Number

10a. State

Maryland

11. Marital Status

Directo

Funeral

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Be Completed

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Examine

Physician/Medical

Completed by

Be

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njurry or other traumatic avent, the Madical Examinat must be notified at once.

Physician /Medical Examiner

> use as the burial-transit attending physician and for use as the burial-tran

been signed by the a should be detached f

To the Hospitel or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene 1 1 5 2 2  Certificate of Death  Beginster											09622	
Decedent's Name (First, Middle, Last)  2, Date of Death Month Day Year  3. Time of Death												
RADOVAN	VI.	AKSENTIJE	VICH						03 /	08	/ 2006	11:15 P M
a. Fecility Name (/	f not institution,	, give street and nu	mber)		4b. City,	Town, or	Location of	of Death		4c.	County of De	eath
5719	Beech A	venue			Bet	hesd	a			M	ontgom	ery
. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year)	9. B	Sinthplace (State or Foreign
086-34-12	274	1√2 M 2□ F	76	Yrs.	Months	Days	Hours	MIII.	Nov.10			Serbia
sual Residence of	Decedent									,		
0a. State	10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
laryland	Monte	gomery	Ве	thesda								1 ☐ Yes 2√∑ No
0e. Street and Nu	mber				10f. Zip	Code				10g. Citi	izen of What	Country?
5719 Bee	ch Aver	nue			2	0817				U	SA	:
1. Marital Status		12. Was Dec	edent Ever in U						ecify Yes or No	)-		nerican Indian,
1 Never Marri	1 Never Married 2 Married 1 Yes 2 No											
3 Widowed	4 Divorced	If Yes, Gir Year or D		1	☐ Yes	2 <b>⅓</b> №	Specify:				Specify: W	nite
(Ѕрес	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working Life, DO NOT use retired)  16b. Kind of Business/Industry											

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) College (1-4or 5+) Chemist

Food

18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) Ivan Aksentijevich 19a. Informant's Name/Relationship (Type, Print)

Leposava Krstic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ivan Aksentijevich - son 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 11, Parklawn Cemetery 2006 Rockville, Maryland

5719 Beech Ave. Bethesda, Maryland 20817

21. Signature of Funeral Service Licenses

22. Name and Address of Facility Advent Funeral Service 7211 Lee Highway Falls Church, VA

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complicati	ons that caused the death. Do not enter the mode of dause on each line.	ying, such as cardiac or respiratory arrest,
Immediate Cause (Final disease or condition resulting in death)	a	Bronchogenic	Carcinoma
,	ſ.	Due to (or as a consequence	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>J</b> "	Due to (of as a consequence of).	

IF FEMALE:										
23b.	Was deced	ent pregnant								
		12 months?								
	1 Tyes	2 🗆 No								
	9 Unknow	wn								

23c. If yes, outcome of pregnancy
1 Live birth 2 ☐ Fetal death
4 Pregnant at time of death
9□ Unknown

1 Inpatient

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
J Cities (Specify)

23d.	Date of de	elivery
	Month	Day

9 Unknown	9 Unknown	
Part II. Other significant condition	contributing to death but not resulting in the underlying cause given in F	Part I.

23e.	Did tobacc	co use con	tribute to the cau	se of death?
	1 🗆 Yes	2 🗆 No	3 Probably	4 Unkno

~~	144		-,			
25.	was	case	referre	a to m	redica	i d
	ахап	niner?				

	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ N
OR Dines of Dooth //	Shoots and sonal

24b. Were auto prior to con death?	psy findings available mpletion of cause of
	2□ No

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 ➡ No 27. Manner of Deat 1 XNatural 2 Accident

h 5 🗆 Pending investigation	28a. Date of Injury (Month, Day Year)
6 Could not be	

Hospital:

ER/Outpatient	3□ DOA	Other:	4 🗌 Nursi
28b. Time of Injury		. Injury at Work?	
	M	1 TYes	2 □ No

g Home	5 Residence	6 ☐ Other (Specify)
28d.	Describe how inj	ury occurred

3 🗌 Suicide 4 Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route N City or Town, State)	e ivumber,
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(Check only one)

1 ☑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) Ave, Suite

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 2006



within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 MARCH 13, Year Physician ANDERSON 9:00 P M ROBERT PAUL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S 8. Date of Birth (Month, Day, Year) 1930 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
W • VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 236-42-1675 75 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other then "natural", or items 23s or 28s-f show event, ite Medical Examiner must be notified at 1 ☐ Yes 2 XNo CHARLES WALDORF Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 16410-A NEWASA LANE 20601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Peges 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "natural", or Ite 1 K Yes 2 No 1947-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à If Yes, Give Year or Dates: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 1950 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE BROKER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SANDS HELEN (UNAVAILABLE) ANDERSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAIRE MAE ANDERSON - SPOUSE 16410-A NEWASA LANE, WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date MARCH 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny injury or once. HUNTT CREMATORY 17, 2006 WALDORF, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HUNTT FUNERAL HOME lark & Brohaum MO0053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician dder /Medical resulting in death) Due to (or as a consequence of): eimer's Dementia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Obstru Ctive 1 Tyes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy treated with Radiation 10 yes perform this certificate ancer 01 Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D45092 30. Na le and address of person who cause of death (Item 23a) (Type, Prin nce Fredrick 31. Date filed (Month, Day, Year) State MAR 1 5 2006

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of N	Maryland		artmen <i>rtificat</i>				lental Hy	/gien	11116	09624
	Physic /Medi		Decedent's Name (First, Middle	Joyc	æ G.	Balo	dersor	ı			2. Date of De Month March	12,	<sup>ay</sup> 2006 <sup>Year</sup>	3. Time of Death 9:45A M
	Exami		4a. Facility Name (If not institution Villa Rosa Nur	sing Home			N	4itch	Location on the control of the contr	ille			4c. County of Death Prince George's	
	Funeral Director		5. Social Security Number 236–48–6941	6. Sex 7. A 1 □ M 2 🖾 F	nge (In yrs. Ia 71	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da April	rth ay, Ye <i>ai</i> 26,	9. Bi	irtholace (State or Foreign Country) West Virgini
	Maryland f show	io	Usual Residence of Decedent  10a. State 10b. County  Virginia Ric	hmond	10c. City,	Town or Lo	ocation	Ta7:	ırsaw					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	i Directo	10e. Street and Number 42 Elliotts D				10f. Zip					10g. C	itizen of What C	Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. itam 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic avent, the Medical Examinational by multiled at	d by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder	? <b>№</b> 0	1	Was Deced If Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	p-	USA  14. Race - Am Black, Wh  Specify: W	eerican Indian, ite, etc. hite
Maryland 21215-0036	e filed within 72 h al Hygiene. I other than "natu vent, the Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	s Education t grade completed) College (1-40)	5+)	(Give life.	dent's Usua kind of wor DO NOT us Healt	rk done d se retired)	uring most	of working	ng	16b, F	Governi	,
yland ;	should be filed ind Mental Hygid markad other umatic avent, II	To Be C	17. Father's Name (First, Middle, I Virgil Gree								(First, Middle,			ment.
	1 and 2 sho Health and I Iam 27 is ma		19a. Informant's Name/Relationsh  Maurice W. Bald  20a. Method of Disposition			42 E	lliot	ts D	rive,	War	saw, V	A 22		
altimore,	Page nent o ant: if ury or		1 ⊠Burial 2 ☐ Cremation  1 ☑ Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (Sp. 21. Signature of uner Service L	ecify)		ce of Disponetery, crem	rove (	Chur	ch  3	/16/		War	ocation - City or	rginia
Ba	permit. Departr Imports any inju		Alman	Mour	ed the death	9	013 A	nnapo	olis	Road	, Lanha	am M	uneral D 20706	5
	Physician /Medical		23a Fart1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	-a. A12	hei.	mer	S		S-e			rrest,		Approximate Interval Between Onset and Death
8760,	icate be executed  physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									Jens		
.O. Box 68	Physician: The law requires that the death certificat this certificate has been signed by the attending phy ral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal de	eath 3	Ectopic pre						23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed by should be deta	β	Part II. Other significant condition	ns contributing to death I	out not resulti	ing in the ur	iderlying ca	use giver	in Part I.		23e. Did to		,	o the cause of death?
Division of Vital Records,	: The law re cate has be . page 2 sho	Completed					····						prior to death?	utopsy findings available completion of cause of
of Vita	Physician: Th this certificate al director, pag	ToB	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inju		VOutpatient		Other	4 Nurs	sing Hom		lence	6 □Other (Spe	cify)
/ision	uttending death. ctor; After y the fune	Certification;	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	(Month, Da	y Year) jury - At home	3b. Time of Injury e, farm, stre	м		ıt es 2∐N	0	3d. Describe h			ural Route Number,
á	To the Hospitai or A within 24 hours after To the Funarai Dira completely filled in bi		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge, death	occurred a	t the time	, date and	olace ar	City or Tow	m, State	and manner on	attatad
	To the H within 24 to the Fi	Medical	(Check only one)  2 Medical E	and manner st	ated.	and/or inv	estigation, i	License r	nion, deatr	occurred	at the time, o	date and	l place, and due	to the cause(s)
	(8)		30. Name and address of person w	ho completed cause of o		За) (Туре, Р	Print)	D		016		3	113/	06
	Star		Rakesh Arora M 31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	е			2 Bow	ie,	Maryla	nd 2	20715	
	Registra	ar	MAR 1	4 2006	des	K	Some?	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Annie M. Bowlding March 2006 1540 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Months Days Hours 579-48-3977 Jan. 6, 1936 70 Wash.,  $_{
m DC}$ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 XYes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7777 Maple Ave., #808 20912 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Yes 2X No 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nathaniel Randolph, Sr. Elizabeth Leach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Bowlding, Jr./Son 2416 Arundel Rd., Mt. Rainier, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 3/13/2006 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Et is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Crus (Final disease or condition resulting in death)

**Physician** /Medical Examiner Certification; To Be Completed by Physician/Medical Examiner

**Physician** 

/Medical

Examiner

Direct

Funeral

ρ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exartirer must be notified at once.

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after deeth To the Funerel Director: , completely filled in by the f the Hospital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	failur Sii	1	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resu	llting in the underlying	cause given in Part I.	23e. Did tobacco  1  Yes 2  24a. Was an autopsy performed?	use contribute to the cause of death?  No 3 Probably 4 Nunknown  24b. Were autopsy findings available prior to completion of cause of death?
				1 Yes 2⊠ No	
25. Was case referred to medical examiner?				ath (Check only one)	
1 ☐ Yes 2 🖺 No	Hospital: 1 ☑ Inpatient 2 ☐ I	ER/Outpatient 3□ D	OA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
29a. Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death occurred ion and/or investigatio	d at the time, date and place, in my opinion, death occ	, e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)

29c. License number

0060100

29d. Date signed (Month, Day, Year)

831 E. University Blvd., Ste. 27

Silver Spring, MD

03-06-6

State Registrar

ca

31. Date filed (Month, Day, Year) MAR 1 4 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (It im 23a) (Type, Print)

HMIN

Kevin Brown 06-01991 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend	item#23a,PIState of Maryland Department of Health and Mental Hygiene	
2		

nd i+am#23a PTT 27 28a-f perMF c85/ //20/06 TT	9	
nd item#23a,PIState of Maryland Department of Health and Mental Hygier	nennc	00626
Certificate of Death Reg.	LUUQ No	0 7 9 2 0

Physician	
/Medical	
Examiner	
Examinici	

**Funeral** Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ie marked other then "natural", or Itame 23a or 28e-f show eny injury or other treumatic event, Ira Medical Exarction must be notified at ODGs. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

> > Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Of Registrar	-		cate of Deal		Reg. I	4000	09526	
an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
al		own	- 1	03. T		March	21 2006	1 20.00	
er	4a. Facility Name (If not institution, give street and num Potomac River off of NSAS			city, Town, or Location ndian Head			4c. County of Dea Charles		
•		7. Age (In yrs. last bir	thday) If I	Jnder 1 Year If Und	der 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)	
	373-82-4208 1 <sup>™</sup> 2□F	36	Yrs. Mo	nths Days Hour		07/09/196	9 Teni	nessee	
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Locatio					10d. Inside City Limits	
jo	VA Fairfax	Alexar		''			1 Tes 2		
irec	10e. Street and Number		10	of. Zip Code			Citizen of What Co	ountry?	
a D	2217 Sweetbriar Drive			22307	7	US	A		
une	v Armed For		13. Was I If Yes	Decedent of Hispanic , specify Cuban, Mexi	Origin? (Specan, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes If Yes, Giv. 3 Widowed 4 Divorced Year or Da	∍ <sup>-</sup> 1005	1 🗆 Y	′es 21X No <i>Spec</i>	ity:		Specify: W	hite	
eted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's	Usual Occupation	nost of worki	na 16b	. Kind of Business	/Industry	
mp	Elementary/Secondary (0-12) College (1-	4or 5+)		of work done during n OT use retired) Employed			ontracto	r	
ပ္ပ	17. Father's Name (First, Middle, Last)		3611	<del></del>	other's Name	(First, Middle, Maio			
To B	Lyman Floyd Brown			Ma	aureen	Ann McCo	nnell		
	19a. Informant's Name/Relationship (Type, Print) Christine Diane Brown/ Wi	C -		dress (Street and Nur etbriar Dr				Zip Code)	
	20a. Method of Disposition	20b. Place of	Disposition	(Name of y or other place)		Date 20c.	Location - City or	Town, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	Male		rematory	3/24	/2006 Da	le City,	VA	
	21. Signature of Funeral Service Licensee		22. Car	nand Address of Fa Cameron S	füncra	1 Home	22214		
	23a. Part1. Enter the disease, or complications that ca	used the death. Do r					22314	Approximate	
	shock, or heart failure. List only one cause on ea	ing complica			us curdiac (	n respiratory arrest,		Interval Between Onset and Death	
	resulting in death)  a								
	Sequentially list conditions b.								
iner	cause. Enter Underlying	or as a consequence	of):						
хаш	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (c.	or as a consequence	of):						
calE	L <sub>d</sub>								
Medi							1		
an/N		come of pregnancy	3 □Ecto	pic pregnancy			23d. Date of de		
ysic	1	ant at time of death wn	5 🗌 Oth	er (specify)			Month	Day Year	
Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to de	ath but not resulting in	the underl	ying cause given in Pa	urt I.	23e. Did tobacc	co use contribute to	the cause of death?	
d be	Alcohol intoxication					1 🗆 Yes	2.00 3 □ P	robably 4 Unknown	
plet						24a. Was an	24b. Were a	utopsy indings available	
EoC					autopsy performed 1 Yes 2	? death?	completion of cause of		
Be	25. Was case referred to medical examiner?				ace of Death	(Check only one)			
٦.		patient 2 ER/Ou	Itpatient 3			me 5 Residence		city) Scene	
tion	1 Natural 5 Pending (Month 2 Xecident investigation Fnd 3/2	n, Day Year)	njury 9:00 A <sup>n</sup>	28c. Injury at Work? 1 ☐ Yes 2	√E No				
III	S Could not be	of Injury - At home, fa ig, etc. (Specify)				Subject fell 28f. Location (Street	and Number or B	ural Route Number	
Ç	Fnd	in water				NSASP, India	an Head, Mi		
Medical Certification; To	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examinar: On the ba and mann	sis of examination an	e, death occ d/or investig	urred at the time, date gation, in my opinion,	and place, a death occurr	and due to the cause ed at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)	
ž	29b. Signature and title of certifier	er	29d.	Date signed (Mon	th, Day, Year)				
	THE WALL		Mar	ch, 22,	2006				
	30. Name and address of person who completed cause	of death (Item 23a)	(Type, Print		Stree	et Baltin	nore Mer	vland	
te	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature	book		DLLCC	L Darell	ore, nar	June	
ar	MAR 2 9 2006	15.0 PS P							
001									

State Registrar

			1 - For State Registrar	State of M	arylan	•	artmen rtificate			and M	ental Hy	/giene Reg. No.	006	09	627
	Physicia /Medic		1. Decedent's Name (First, Middle, La Earl R. Bu	,							2. Date of De Month March	eath Day 10	2006		of Death
p.	Examin		4a. Facility Name (If not institution, given Peninsula Region	al Medical	Cent		Sal	isbu					County of Deal		
l	Funeral Director			Sex 7. Ag	9e (In yrs. I	ast birthday) Yrs.	If Under Months		If Under : Hours	Min	8. Date of Bi (Month, Di Dec. 1	8, 191	9. Bird	hplace (Stat untry)	e or Foreigr
	ne Maryland 8a-f show	ector	MD Worcest	er	10c. City	Ocean	Pine								City Limits
	ith with the 23s or 2	Funeral Director	266 Windjammer R	d.			10f. Zip	<sup>Code</sup> 2181	1			10g. Citiz US	en of What Co	untry?	
3	72 hours after death with the Maryland natural; or items 23s or 28s-f show lical Examination invalled at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1/2/2/es 2  If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	pecify Yes or No- o Rican, etc.)  14. Race - America Black, White, et Specify: Whit				,
-	thin 72 hours e. en "natural", Medical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	life. I	kind of woi DO NOT us	rk done a	lurina most	ol workii	ng	16b. Kin	d of Business	Industry	
1	permit. Pages 1 and 2 should be filed within 72 h. Dep_urment of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturany nijury or other traumatic event, the Maulical once.	To Be Con	17. Father's Name (First, Middle, Lass Franklin Pierce	•		Sa	les		18. Mothe		(First, Middle		Struct Sumame)	ion Co	mpany
, ma ,	l end 2 shortealth and Norm 27 ie ma		19a. Informant's Name/Relationship  Gracie Busch  20a. Method of Disposition	Туре, Print)	20h D	266	Wind	iamm	er Rd	., 0		ines,	Town, State, 2	1811	
	mit. Pages purtment of the cortant: if its righty or of		1 ☐ Burial XIXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)		lace of Dispo emetery, cren De Hen	lopen	Cre	m.	3-1	3-06	Fran	kford, neral l	DE	
<u> </u>	Depure		Jacqueline L. Ra	fferty (per	DVR)						rlin,			TOME	
1	Physicien and /Medical Examiner transit sthe private transit	l Examiner	23a. Par1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	ine.  (E C)  a consequence a consequence  y pro	REMU LETER LET	CAN Y SU	wkt Rhen	g, such as	cardiac o	r respiratory a	arrest,		Approximinterval E Onset an IOA	Between
C. POY 001.0	To the Hospital or Attending Physicien: The law requires that the death certificate b within 24 hours effer death within 24 hours effer death. To the Ameral Director: After this certificate hes been signed by the attending physic completely filled in by the funeral director, page 2 should be deteched for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal	death 3	Ectopic pro					2:	3d. Date of del	ivery Day	Year
	juires thet the signed by a detection	ρ	Part II. Other significant conditions	contributing to death t	out not resu	ulting in the u	nderlying ca	ause give	en in Part I.			tobacco us	se contribute to		of death?
	nysicien: The law rec his certificate hes beer I director, page 2 shot	Completed											24b. Were au prior to death?	topsy finding	gs available of cause of
	sicien: s certific lirector,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🗶 Inpati	ont 201	ER/Outpatien	it 3 DO	Othe			(Check only		CO /C		
5	ending Physath. or: After this he funeral o		27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work		2	28d. Describe		Other (Spe	cny)	*
	ital or Att urs efter de rai Directi lled in by t	Certification:	3 Suicide 6 Could not to determined	building, e	e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Ric City or Town, State)									umber,	
	the Hosp nin 24 hou the Fune npletely fil	<b>ledica</b>	one)	hysician: To the best miner: On the basis o and manner st	at examinat	wledge, death tion and/or in	vestigation,	, in my op	oinion, deat	d place, a	and due to the ad at the time,	, date and	place, and due	to the caus	
)	To To	Σ	29b. Signature and title of certified				(	License					signed (Mont		·)
H	5+1		30. Name and address of person who James Todd	100 East				Sal-	isbur	y, Mo	d. 2180	02			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 5 2006

		Plea	se Type or l	Print in B	lack In	delible Ink.	Ensure	All Copies	Are Le	aible.		
	•	For State Registrar			d / Depa	artment of H	ealth and	Mental Hyg			1962	
	1 9	1. Decedent's Name (First, Middl	e, Last)					2. Date of Dea	ıth	Vani	3. Time of I	Death
Physicia /Medic		Virginia	Irene Bake	er				March	Day	2006	0117	М
Examin		4a. Facility Name (If not institution		,		4b. City, Town, or		th		unty of Death		
		Washington Co  5. Social Security Number		tal 7. Age (In yrs. la	act highdays	Hagers	town If Under 24 Hr	S 0 0-1- of 0:at		hington		-
Funeral Director		214-09-7090	1□M 2□F	88	Yrs.	Months Days	Hours Mir		, Year)	Mary		Foreign
		Usual Residence of Decedent						Julie 27,	1/1/	riar y	Land	
72 hours after death with the Maryland 72 hours after death with the Maryland 172 natural; or Items 23s or 28s-1 show disal Examiner must be notified at	_	10a. State 10b. County		10c. City	, Town or Lo	cation				•	10d. Inside Cit	
he M 28a-1	Directo	Florida India	n River	Se	bastia						1 T Yes	2 [ 140
with t		1702 Sunrise	Lano			10f. Zip Code 32958	Q		-	of What Cou	-	
urs after death v	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13.			Specify Yes or No-		ed Star		-
after dea		1 Never Married 2 Mar	Armed Fo ned 1 ☐ Yes	rces? 2 XNo		Was Decedent of Hi f Yes, specify Cuba		rto Rican, etc.)	1	Black, White,		
ours ours	d by	3 X Widowed 4 □ Divorced	If Yes, Giv Year or Da			1□Yes 2XINo	Specify:		Sp	ec <i>ify:</i> wh:	ite	
72 hours "natural",	Completed		it's Education st grade completed)		(Give	dent's Usual Occupa kind of work done of	furing most of wi	orking	16b. Kind	of Business/In	dustry	
filed within Hygiene. sther than ant, the Mile	шр	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOTuse retired, <b>fice wor</b> l	•		. d	- <b></b>	£	
filed Hygir Sther		17. Father's Name (First, Middle,			01	TICE WOLL		ame (First, Middle,			nufactu	ire
ild be lental ked o	To Be	Charles Paul	Grove				Haze1	Irene Wo	lvert	on		
should and Men s marks	-	19a. Informant's Name/Relations	ship (Type, Print)			ng Address (Street a						
and 2 ealth a n 27 is		Lois Smith	n	iece	17008	Hillsda	le Court	#90 Hag	ersto	wn, Mai	cyland	21740
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If tiem 27 is marked other than "nn any Injury or other traumatic event, the Mach 2008.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5	on - City or To									
permit. Departm Importa any Inju	1	21. Signature of Funeral Service		- 100		2. Name and Addres		Minnich :	Funera	al Home	2	
8258			Lestal			.5 E. Wils				, Maryl	Land 21	740
		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that conly one cause on e	ach line.							Approximate Interval Betw Onset and D	veen
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			10 CAPPA	MIN	FARLTI	OM		011001 4114 5	
Examiner		,	Due to (	or as a consequ	ence of):	TIME SM	01 6 70	1-141 1)6	STELL	ITIAN	1	
	er	Sequentially list conditions, if any, leading to immediate	b. (V > 8	or as a consequ	ience of):		ALC ISU	Walter	,3170	re trop	1	-
cuted	min	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .	PAH	CPEA	TITIS						
be execticien and burial-tra	EX	resulting in death) Last	Due to (	or as a consequ	ience of):							
icate be	lical		d								-	
ertific ding p	Mec	IF FEMALE:	00-15									
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come of pregnar inth 2 Tetal ant at time of de	death 3[	Ectopic pregnancy			23d	Date of delive Month		ear
that the de	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno		aun 5	Other (specify)	·		15			
res that igned by		Part II. Other significant conditi	ons contributing to de	eath but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of de	eath?
quires n sign	ed by	MYSTER	& CTOM	Y/HM	PEF-	TUNS 101	μ,	1 🗆 Y	es 2□N	lo 3□Prot	ably 4 🗆 U	nknown
s been si	Completed	SKINAL	5 TEN	0515.	NON	14510H	5.	24a. Was a		4b. Were auto	psy findings a	available
The lav	Eo							autop perfor	med?	prior to co death? 1 \( \sum \text{Yes}	mpletion of ca	use of
elcian: Th certificate rector, pag	Bec	25. Was case referred to medica examiner?	1				26. Place of De	eath (Check only or		1 🗆 1 63	20140	
hyeld his ce	ို	1 ☐ Yes 2 ☐ No			ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Resid	lence 6	Other (Special	<b>'y</b> )	
ling P	ion:	27. Manner of Death 1 Natural 5 □ Pendi	14	of Injury th, Day Year)	28b. Time o Injury	Work	ς?	28d. Describe h	ow injury or	curred		
death death ctor: / the	icat	3 ☐ Suicide 6 ☐ Could		of Injuny - At ho	me farm et	M 1 1 1	Yes 2□No	28f. Location (S	Stroot and N	umber or Dur	al Davita Mumb	ha s
il or A after Direction by	Certification:	4 Homicide determ	buildi	ng, etc. (Specify	()	eet, ractory, onice		City or Tow		uniber of Aure	ar Modie Ivarni	rer,
spita hours meral		29a. Certifier	ng Physician: To the	best of my know	wledige, deat	h necurred at the tim	ne, date and plac	ne, and this turther	rauso(s) ani	d marmer as s	Letel	
To the Hospital or Attanding Physician: within 24 hours after death to the Funeral Director: After this certifica completely filled in by the funeral director.	edicai	(Check only 2 Medical one)	Examiner: On the ba	asis of examinat ner stated.	ion and/or in	vestigation, in my or	pinion, death occ	curred at the time, o	date and pla	ice, and due t	o the cause(s)	
To t To t	Σ	29b. Signature and title of certifie	/ \			29c. License		707	29d. Date s	gned (Month,	Day, Year)	
		P VP.	) M					327	3/1	6/00	0	
d1 12		30. Name and address of person	who completed caus	se of death (Item	23а) (Туре,	Print) RINA	BANSI	14	7 1 -	110		
H-12		2	00 1110	9 1-	r ( F	O CAST	on 17,	( ()	217	40		

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Pay, Year), 2006



ORIGINAL

		1 - For State Registrar	State of Maryland /	Department of He		3	53117"	09629
	NE 11	Decedent's Name (First, Middle, Last)		Octimodic of L	Joann	Reg. No.		3. Time of Death
Physi /Med		Annie Brown				Month Da March 11	2006 Year	5:45 a <sup>M</sup>
Exam	niner	4a. Facility Name (If not institution, give s	reet and number)	4b. City, Town, or	Location of Death		. County of Death .nne Aru	ındo1
Funera Directo		Future Care 5. Social Security Number 6. Sex 215-18-7846	7. Age (In yrs. last to 95	ointhday) If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 8 19	9. Birthi	place (State or Foreign
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
ie Marylan Ba-f show	Director	Maryland Anne Ar	undel Anna	polis				1 Yes 2 No
3a or 2	I Dire	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
ite, INIAL Y IAILIA Z. I.Z. 1970.50 s. 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is merked other than "natural", or Items 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	2140 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	USA  14. Race - Americ Black, White,  Specify: B1	
72 hour	eted	15. Decedent's Educ (Specify only highest grade	ation 16	ia. Decedent's Usual Occupa (Give kind of work done di	uring most of work	16b. k	(ind of Business/In	dustry
d within jiene. r then	Completed	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	life. DO NOT use retired)  Domesti		Pri	vate Fa	milv
al Hyg	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, Maider		. m.r.r.y
Idi yidilid Kiki 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	To	George Martin				Alice Joh		
and 2 st and 2 st ealth and m 27 is n		19a. Informant's Name/Relationship (Type Phyllis Smith (G		9b. Mailing Address (Street a $1606 \;\;  ext{Col}-1$				
Dallinole, We permit. Pages 1 and 2 Department of Health & Important: if Itam 27 is any Injury or other tra		20a. Method of Disposition  P☐Burial 2 ☐ Cremation 3 ☐ Re	20b. Place	of Disposition (Name of tery, crematory or other place gate Memora	31	Date 20c. L	ocation - City or T	own, State
mit. Pages partment of portant: If It		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	Garde	22. Name and Address	3/1	6/06 Ann	apolis,	Md.
permit. Departi Import	500	Larry B, A	cese M00483			Mortuary apolis, M	á. 2140	1
Physicial /Medica Examine	al	23a. Part 1. Enter the sease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	rascula		1	2	Approximate Interval Between Onset and Death UCA S
cate be executed physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
physicien the burial	dlcai	L a						
The Cold us, F.C. DOX 00100,  The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burrat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9  Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3⊟Ectopic pregnancy 5⊟ Other (specify)			23d. Date of deliv Month	ery Day Year
requires that	≥	Part II. Other significant conditions con	nbuting to death but not resulting	g in the underlying cause give	on in Part I.	23e. Did tobacco 1 ☐ Yes 2		he cause of death?
vital necolus sician: The taw require s certificate hes been sig firector, page 2 should b	Completed					24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
riclan: clan: ector, p	Be	25. Was case referred to medical examiner?				h (Check only one)		
Physic this c	1	1 Yes 2 No		Outpatient 3 DOA Othe	AND Nursing Ho	me 5 Residence		(y)
nding ath. r: After	ation	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work	res 2 🗆 No	28d. Describe how inju	ry occurred	
al or Atte s after dea id Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Street a. City or Town, State	nd Number or Run e)	al Route Number,
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 17 Cartifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowled ar: On the basis of examination and manner stated.	ge, death occurred at the tim and/or investigation, in my op	e, date and place, inion, death occur	and due to the cause(s red at the time, date an	and manner as s d place, and due t	stated. the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	1 10 -1	29c. License	number	29d. Da	ate signed (Month,	Day, Year)
		30. Name and address of person who co	npleted cause of death (Item 23a	i) (Type, Print) ,	012	) 3	-15-	000b
		Jenniter Riec	Inger 860	1 Veterans	Hwy	M. Uersi	ille,	ND 21108
- S Regis	State	31. Date filed (Month, Day, Year)	22. Registrar's Signature	Andre	0		,	

			1 - For State Registrar		of Maryla		artmen rtificat				R	eg. No.		09630	
	Physici		1. Decedent's Name (First, Mid Robert Heart	-							2. Date of Dea Month March	Day 10	2006	3. Time of Death 4:40 P M	
	/Medic Examin		4a. Facility Name (If not instituti Ginger Cove						Location o		raten	4c. Co	ounty of Death Anne Ar		
	Funeral Director		5. Social Security Number  121-07-4383  Usual Residence of Decedent	6. Sex 1 X M 2 □		s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day arch 2.			place (State or Foreign htry) York	
	with the Maryland to c 28a-1 show	Director	10a. State 10b. Coun	Arundel		city, Town or Lo	10f. Zip				1	0g. Citizei	n of What Coul	1 Yes 2 No	
3036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f ehow event, the Mudical Examiner must be multified at	by Funer	9104 River Cres 11. Marital Status 1 Never Married 2 Marital Status 3 Worldowed 4 Divorce	12. Was I Armed 1 77 /	Decedent Ever in 1 Forces? Ses 2 No 19 Give	U.S. 13. 41- 46				gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	United States  14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0036	within 72 h ine. .hen "natu	Completed		-	e (1-4or 5+)	(Give	DO NOT u	rk done d se retired,	luring most )		g		of Business/In		
Maryland 2	0 = 0 >	Be	17. Father's Name (First, Middle Frederick D. Ba	, Last)	4	Open	ration	is Ma		r's Name	(First, Middle, Hearn		ine Ind	iustry	
Mary	d 2 should be h and Mental 7 le marked ( traumatic ev	-	19a. Informant's Name/Relation	ship (Type, Print)		1					Route Number				
altimore, I	ages 1 end 2 int of Heelth t: If Item 27 I y or other tra		Carol B. Curtis  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other	3 □Removal fr	20b. om State	Place of Dispo cemetery, cre	osition (Name of the control of the	ne of other place	9)	ourt Da /13/2	ite	20c. Loca	tion - City or To	d 21045 own, State faryland	
Baltir	permit. Pages 1 end 2 should b Depertment of Heelth and Ments Important: If Item 27 Is marked enty liqury or other traumatic e <u>once.</u>		21. Signature of Funeral Service		Me	2:	2. Name ar	nd Addres	s of Facility	y Joh	n M. Ta	aylor	Funera	al Home, Inc.	
8760,	Physician //Medical Examiner properties of the primaritans of the primaritans of the primary of	lical Examiner	d												
P.O. Box 6	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Li 4 ☐ Pi	outcome of pregive birth 2 Fe regnant at time of nknown	tal death 3[	⊒Ectopic pa ⊒ Other (sp					230	I. Date of delive Month	ery Day Year	
	w requires that been signed b should be deta	کِ	Part II. Other significant condi	tions contributing	o death but not re	esulting in the u	inderlying o	ause give	on in Part I.		23e. Did to			he cause of death?	
al Records,	Physicien: The law re ir this certificete has bee aral director, page 2 sho	Completed									24a. Was a autopo perfor		24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of	
<b>\frac{1}{2}</b>	s certif	o Be	25. Was case referred to medic examiner?  1 Yes 2 No	Hospital:	□Inpatient 21	DEB/Outpation	ot 3[] D(	Othe	-		Check only or e 5 ☐ Reside		70th (C		
Division of Vital	Attending Phy r death.  •ctor: After this by the funeral c	ation: To	27. Manner of Death 1 Natural 5 ☐ Pend	28a. D	ate of Injury Month, Day Year)	28b. Time of Injury		8c. Injury Work		21	Bd. Describe h			y) 	
Divis	in Life	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined   289. P	ace of Injury - At uilding, etc. (Spec	home, farm, st	reet, factor	y, office		2	8f. Location (S City or Town		lumber or Rura	al Route Number,	
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certify (Check only one) 1 Medic	ing Physician: To il Examiner: On the and r	the best of my kille basis of examination	nowledge, deal nation and/or in	h occurred evestigation	at the tim , in my op	e, date and pinion, deat	d place, as th occurre	nd due to the c d at the time, d	ause(s) an ate and pl	d manner as s ace, and due to	tated. o the cause(s)	
`	To th To th comp	Me	29b. Signature and title of certif	1 B3	181.11	120		. License					igned (Month		
•			30. Name and address of person	n who completed	cause of death (Ite	em 23a) (Type,		100	)29	7 (		05	113/:	2006	
	Sta		Paul B. Berez,		225 Defe		y., S	uite	E C	rofto	n, Mar	yland	21114		
	Registi		MAR 14		server to	to Some	The s								

			1 - For State Registrar	State of N	/larylar	•	artment of			-	giene 06	30	9631	
	Physici	o on	1. Decedent's Name (First, Middle	), Last)						2. Date of Dea Month	Day	Year	3. Time of De	ath
	Physici /Medic		William	С.		Burne				March	9 2006		0415	М
	Examin	er	4a. Facility Name (If not institution	•	-		4b. City, Town				4c. County o			
	r	186°	Anne Arundel				Anna If Under 1 Ye	apolis	er 24 Hrs.	Anne Arundel				
	Funeral		5. Social Security Number	6. Sex 7. / 1 X M 2 ☐ F	49 (In yrs.	last birthday) Yrs.	Months Da			8. Date of Birt (Month, Da	, Year) 1956	9. Birthpl	lace (State or Fo	oreign
<b>E</b>	Director	4	216-72-8082 Usual Residence of Decedent		49					Julie o	, 1950	COTO	rado	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10	0d. Inside City L	imits
	Man	ģ	MD Anne	Arundel	A:	rnold							1 ☐ Yes 2	XNo
	atter death with the Marylan or Items 23a or 28a-f show in cer mint by colified at	Director	10e. Street and Number		_1		10f. Zip Cod	е			10g. Citizen of W	nat Coun	try?	
	h wit	aiD	1516 Briarcli:	ff Road				21012			USA			
	dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U	l.S. 13.	Was Decedent of If Yes, specify C	of Hispanic (	Origin? (Spe	city Yes or No	14. Race	- America , White, e	an Indian,	
9	after or It		1 Never Married 2 Marr			1	1 ☐ Yes 2 💥 I					Whi		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f ahow offsal Ezan, net man be confitted at	d by	3 Widowed 4 Divorced	Year or Dates	S:									
7	_ = 10	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		(Give	dent's Usual Oc <i>kind of work d</i> o DO NOT use re	<i>ne durina</i> m	ost of worki	ng	16b. Kind of Bus	iness/Ind	iustry	
12	d within jiene. r than "	m du	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Carpe		urea)			Contrac	+0*		
d 2	be filed htal Hygid od other event, I		17. Father's Name (First, Middle,	<del></del>		Carpe	siiter	18. Mo	ther's Name	(First, Middle,	Maiden Sumame			
an	fental fental rked o	To Be	Jack Burnett					No	rma C	astee1				
Maryland	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Str				er, City or Town, S	itate, Zip	Code)	
	2 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Robert Burnet	t (Brother)		1711	Porters	s Hill	Road	, Annap	olis, MD	214	01	
ē,	He He tem		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other	n/aca)		ate	20c. Location - C	ity or To	wn, State	
Ę	Pages nent of int: If It		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		te	-	ematory	<i>D1409</i> /	3-14	-2006	Baltimo	re,	MD	
altimore,	그 본론을		21. Signature of Funeral Service				2. Name and Ad	dress of Fac	cility	17				
ä	Department of the partment of	1	178-9.6	-			12 Ric	sty ru igely	inerai Avenu	Home, e, Anna	r.A. polis, M	D 21	401	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the deat	th. Do not ent							Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	,	Du	011411	2110	,					Onset and Dea	
1	/Medical		resulting in death)	Due to (or a	as a consec	quence of):	2		4	t		-	nay.	
	Examiner		Sequentially list conditions	b	Gura	d-Sta	se Rei	20	de	seas	ر ا		year	N
	D iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or a	as a consec	quence of):		0						
	and I-tran	Examine	that initiated events resulting in death) Last	C. Due to (or a	HY	poth	your	علا					year	<u> </u>
8760,	cate be executed obysiclan and the burial-transit			200 10 (01 2	as a corpsof	11	Lean	. ~					1100	
687	death certificate e attending phys of for use as the	Physician/Medical		d		110/10	2790	uch		-			gen	v
	eath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregn	ancy		-			23d. Date	of delive	erv	
Вох	atter d for u	ciar	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant			Ectopic pregna Other (specify				Mont		Day Yea	ir
0	by th ache	hysi	9 Unknown	9□ Unknown	1									
ď.	w requires that is been signed by should be deta	by P	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlying cause	given in Pa	rt I.	23e. Did to	obacco use contril	oute to th	e cause of deat	th?
ğ	requires leen sign hould be	ed	Vialeter							10	res 2□No 3	3 ☐ Proba	ably 4 ☐ onk	nown
Vital Records,	E 2 C	Completed								24a. Was	an 24b. W	ere autop	psy findings ava	allable
Ř	The ate h page	ĕ								oheq	rmed?/ de	eath?	210No	,0 0.
ita/	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Pla	ace of Death	Check only o	me			
<del>6</del>	Physician: this certific ral director,	၉	1 ☐ Yes 2 ₺ No	Hospital: 1 Linpa		ER/Outpatier	IL SEL DON				dence 6 Othe		)	
n		in o	27. Manner of Death 1 □ Natural 5 □ Pendin	9 -	njury Da <i>y Year)</i>	28b. Time o Injury		Nork?		28d. Describe I	now injury occurre	d		
Sic	at : at	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be 290 Place of I	Injuny . At h	ome farm et	M eet, factory, offi	Yes 2		28f Location /	Street and Numbe	r or Rura	I Poute Number	r
Division	l or Attendation after deati	Certification:	4 ☐ Homicide determ		etc. (Speci		eet, factory, on	Ce		City or Tox		or riara	THOUSE THURSDES	,
_	To the Hospital or Attervithin 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier 1 Certifyin	ig Physician: To the bea	st of my line	wiedge, dast	h occurred at th	a time, data	and plans.	and dual to the	couse(s) and yan	ner as at	Blad	
	the Ho hin 24 h the Fu npletely	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examina stated.	ation and/or in	vestigation, in n	ny opinion, d	leath occurr	ed at the time,	date and place, ar	nd due to	the cause(s)	
	To th vithir To th comp	Me	29b. Signature and title of certifie	5				ense numbe			29d. Date signed	(Month, I	Day, Year)	
			Home J. C	Jains 1	$n \cap$		I	)53	111		3/9	16		
			ou. Name and addr is person	who completed cause o							/ /	401		
				vis, MD			al Park	way, A	nnapo	lis Mar	yland 21	.401		
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4	2006 Megis	strar's Sign	ature do	de							

			For State Registrar		State	of Mary	/land / [		rtment of			lental Hy	giene Reg. No.	006	096	32
			Decedent's Name (First,	Middle,	Last)							2. Date of De	ath		3. Time	of Death
	Physicia	-	Mary Jan	e	Bromley							Month	Day	2000	00	U < M
į	/Medic Examin		4a. Facility Name (If not ins			ımber)			4b. City, Town	, or Location	of Death	11 4010	4c. (	County of Dea	2 1 2	
			Peninsula H	egin	m/ med	iral	rent		50	lichi	al		11	VICON	in	
F	uneral		5. Social Security Number	gie	6. Sex	7. Age (II	n yrs. last bii	thday)	If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State	or Foreign
	irector		218-24-4701		1□M 2/F	74		Yrs.	Morius Day	s Hours	MILL.	05-10-			yland	
Б	>		Usual Residence of Deced	ent County		10	c. City, Tow									
I 6 1 6 1 6 1 6 1 6 1 6 1 6 1 6 1 6 1 6	or items 23a or 28a-f ehow Italier must be calified at	2	100. 0	Journey		,,	G. City, Tow	n or Loc	ation						10d. Inside (	s 2 No
₩ W	Ba-f	Director		mer	set	:	Prince	ess .								3 2 110
vith ti	or 2	H	10e. Street and Number						10f. Zip Code				10g. Citiz	en of What Co	ountry?	
ath v	items 23a cermusi	ā	12208 Some	erse					218					JSA		
er de	llem Ber	Funeral	11. Marital Status	<b>-</b>	12. Was Dec	cedent Eve orces? 2 X No	rin U.S.	13. W	as Decedent of Yes, specify C	f Hispanic Oi Jban, Mexica	rigin? (Sp in, Puerto	ecify Yes or No Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, White</li> </ol>		
rs aft	ō	by F	1 ☐ Never Married 2[ 3 ☑ Widowed 4 ☐ Di		lf Yes, G Year or I	ive '		1	□Yes 2	lo Specify	<i>'</i> :			Specify:		
3 8	Ema		/\		Education	Jaies.	162	Docode	ent's Usual Occ	unation			1 Ch Via	Wit d of Business	nite	
n 72	a di	Completed	(Specify only	highest	grade completed		102	(Give k	ind of work do O NOT use ret	e durina mo:	st of work	ing	TOD. KIN	a or business	industry	
with a	1 3	E	Elementary/Secondary (	0-12)		(1-4or 5+)	Di		cian	,			Ctol	te_Hosp	sital	
filed Hvd	of other than "natu		17. Father's Name (First, A	Aiddle, L	none ast)			Leti	Clair	18. Moth	er's Nam	e (First, Middle			JILAI	
d be	b 0	To Be	Milton Mill	e						Minn	ie J	ones				
should be	le marked other then aumatic event, it e Ms	H	19a. Informant's Name/Re	_	ip (Type, Print)		195	. Mailing	Address (Stre			al Route Numb	er, City or	Town, State,	Zip Code)	
and 2	Item 27 le marke other traumatic		Sue Bromley	/Dai	ohter							arrento				
7 - 4 g	othe		20a. Method of Disposition	•	giller	1	20b. Place o	f Dispos	tion (Name of		e, wa	Date		ation - City or		
Pages Pages	Y or		1 Burial 2 □ Crem 4 □ Donation 5 □ O					-	atory or other p		) 2 / 2 <b>0</b>	/2006	Dain		mo MD	
H. P.			21. Signature of Funeral S		P		вееспи		Cemete	-			PITH	cess Ar	me, m	
permit.	Important: If Item 27 le		MAN X	W	una	A MO	0295		Name and Add							
		10	23. Part1. Enter the as	ase or c	complications that	4-4		not ente	the mode of o	nerset	AVE	. Prin	cess	Anne,	MD 218	
		1	shock, or heart failur Immediate Cause (Final	e. List o	nly one cause 🐲	each line.			0						Interval Be Onset and	etween Death
	sician ledical		disease or condition resulting in death)		a		CAPN		KE 2	PIKA	1000	+ FAI	cui	CE	IDDA	745
	miner				Due to	orasaco	onsequence	or): Ll V (	OD VEN	THE	TIC	in S	IND	Rana	64E	ARC
		6	Sequentially list conditions if any, leading to immediate	i.	D		onsequence	<u> </u>	VC	- 1 - 1	, (, ~		1100	TOME	BIE	71/3
ted	nsit	Examiner	Cause (Disease or injury	4	1	,	,									
be executed	sician and burial-transit	xa	that initiated events resulting in death) Last	1	c Due to	(or as a co	onsequence	of):				-				-
3 8	siciar buri	dical E		- 1												
ficate	physics the t	edic			O											
certi	nding use a	N/	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, or								2	3d. Date of de	livery	
eath C	atter I for u	ciar	in the past 12 months			birth 2 [ nant at tim	Fetal death e of death		Ectopic pregnal Other <i>(specify)</i>					Month	Day	Year
, P	ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unki											
that	deta		Part II. Other significant of	ondition							1.	23e. Did t	obacco us	e contribute t	the cause of	death?
	been signed t should be det	d by	CONGI	= 57	IVE H	IEAG	ZT !	FA	ILURI	<u>=</u>		1 🗆	Yes 2	No 3 □ P	robably 4	]Unknown
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D 80	tor: After this certificete hes the funeral director, page 2	E	ATRIA									auto		prior to death?	utopsy finding: completion of	cause of
<u>ا</u> ا	fficet or, pa	ပိ	25. Was case referred to r		FIBR	100	ALL	91	3			1 Yes	2 1No	1 🗆 Yes	2 □ No	
sicia	rect	00	examiner?	Hedical	Hospital:	Mastiant	2 ER/0		2004			h <i>(Check only o</i> me 5 ☐ Resi		Go# . /0		
2 £	er this	. To	27. Manner of Death		28a. Date	of Injury	28b.	Time of	28c. Ir	ury at	ursing Ho	28d. Describe			сіту)	
e a f	. Afte	tio		Pending investiga	(Mo	nth, Day Ye	ear)	Injury		∛ork? ∐Yes 2.⊑	]No		, ,			
Atte	oy the	ifica	3 ☐ Suicide 6 ☐	Could no	ot be 28e. Plac	e of Injury	- At home, fa	arm, stre	et, factory, offic	:е		28f. Location (		Number or R	ural Route Nu	mber,
5 5	d in	Certification:	4  Homicide		buik	ding, etc. (	Specity)					City or To	wn, State)			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effor death.	To the Funeral Direct completely filled in by		29a. Certifier 1 C	ertifying	Physician: To th	e best of m	ny knowledg	e, death	occurred at the	time, date a	nd place,	and due to the	cause(s)	and manner a	s stated.	
0 H €	ne Fi	edicai	(Check only 2 Mone)	edical E	xaminer: On the and ma	basis of ex nner stated	amination ar I.	nd/or inv	estigation, in m	y opinion, de	ath occur	red at the time,	date and	place, and du	e to the cause	(s)
Total	Tot	Ž	29b. Signature and title of	certifier	M		3	1.	29c. Lice	ense number	10		29d. Date	signed (Mon	th, Day, Year)	
			•		1900		71.	/ 7 0	1	> 4	076	2	IVIA	KCH	1+,	2006
			30. Name and address of	oerson w	who completed cau	se of deat	h (Item 23a)	(Туре, Е								
			30. Name and address of M · S H I R	421	`W.D.	PEN	INS	ulf	ME	100	ECA	PROLL ST	. SALI	sbunyn	10.	D 41001
	Sta		31. Date filed (Month, Day	, rear)	32.	Hegistars	Signature									
	Registr	ar	M.F	IR 2	1 2006	Fig.	eta a d	M	Brack 1	,						

			1 - For State Registrar	Stat	te of Ma	aryland		•				lental H			
			1. Decedent's Name (First, Middle, Last)  Certificate of Death									2. Date of E	Reg. N	.00	3. Time of Death
	hysici /Medic	edical Henry Burgan, Jr.									MARCE	H 10, 2006 12:35			
Ε	xamin	er							city, Town, o		of Death			c. County of Death	
	va MARYLAND HEALTH CARE SYSTE							ERRY					CECIL		
	neral ector		5. Social Security Number 219-10-0948	6. Sex 1 🔀 M 2	7.6	e (In yrs. Ia Bl	est birth Yı	Mon	ths Days	Hours	Min.	8. Date of E (Month, I Aug.	DAV YAR	COL	place (State or Foreign intry) ryland
and	. T		Usual Residence of Decedent  10a. State 10b. County	,		10c. City	. Town	or Location							10d. Inside City Limits
Mary	ied a											18∏Yes 2 □ No			
the	289	rec	10e. Street and Number	arrora				10f	Zip Code					Citizen of What Country?	
h with	81 Pe	<u>e</u>	114 Linwood A	venue						210	14			U.S.	Α.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	or Itams	Funeral Director	11. Marital Status  1 Never Married 2 Mar	ned 1 🔀	Decedent E ed Forces? Yes 2 \( \) N		S	If Yes,	specify Cuba	an, Mexic	an, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - Ameri Black, White	
hours	al Exam	d by	3 ☐ Widowed 4 🖾 Divorced	Yea	es, Give r or Dates: V	WW II			s 2X No	Specify	y: 				White
ithin 72	Madica	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	<del></del>	eted) ege (1-4or 5-	+)	(4	Give kind o	Jsual Occup f work done T use retired	during mo	luring most of working				,
fed w	nt, the		Nine Years	1 +3				Trı	ick Dr						ss Trucking
ibe fi	. evar	Be	17. Father's Name (First, Middle, Last)  Henry Burgan							, .		,			
hould d Me	mark	2	19a. Informant's Name/Relations		J		10b A	Anilina Add	rana (Strant	and Num	horar Rus	Mary		or Town, State, Zi,	- O- d-)
d 2 s	trau		Ella H. Rosier	(Sis				_				imore,			1220
1 ar	other		20a. Method of Disposition	, , , , ,		20b. Pl	ace of D	Disposition	Name of	1	-	Date	_	Location - City or T	
r. Pages	Jury or		1 ☑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5	Specify)	from State			Fores	or other place. Cemete	ery		.7/06	Owi	ngs Mills	, Maryland
Depar	any ir		21. Signature of Funeral Service	Licersee	JEVQ6	n, ć	J.	Lee	and Addre A. Pat yvilla	tters	on &		unera 903-0	al Home,	P.A.
Phys	ician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	only one cause	that caused on each lin	Θ.	Do no							M.Gallin	Approximate Interval Between Onset and Death UNKNOWN
	dical niner		resulting in death)		ue to (or as a		ence of)	):							
pe pe	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Unserse or Injury)												
*, execut	al-tran	Examiner	that initiated events resulting in death) Last	c	ue to (or as a	a consequ	ence of)	):							
cate be executed	pnysician and the burial-transit	dicali		d											
	ng pr	a ·	IF FEMALE:			-									
Attending Physician: The law requires that the death certificated by the continued by the strong conti	signed by the attending pri be detached for use as t	Physician/M	1 I Live birth 21 Fetal death 31 Ectopic pregnancy									23d. Date of deliv Month	•		
s that	e det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Dia	23e. Did tobacco use contribute to the cause of death?			
aduire	should b		PARKINSON'S	DISEAS	E BE	ENIG	N Pl	ROST	ATIC			1 🗆	1 Yes 2 No 3 Probably 4 Unkno		
The law r	N C	Completed	HYPERTROPHY COMPRESSION FRACTURE LUMBAR  24a. Was an autopsy perform								opsy formed?	prior to co death?	opsy findings available ompletion of cause of		
- in a	rector, pag	a	SPINE 25. Was case referred to medica	1		-				26. Plac	e of Death	1 ☐ Yes h (Check only		o 1 Tes	2 U No
ysici	al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	1 🔀 Inpatier	nt 2 🗆 E	R/Outp	atient 3	DOA Oth	or				6 ☐Other (Special	ly)
ding P	Je L		27. Manner of Death  1 Natural 5 Pendin	ng	Date of Injun (Month, Day	Y Year)	28b. Tin Inju		28c. Injun Worl	y at k?		28d. Describe			,
To the Hospital or Attendition within 24 hours after death.	d in by the	Certification;	2 Accident investigation   M   1 Yes 2 No   3 Suicide   4 Homicide   4									al Route Number,			
the Hospital or	letely fille	Medical (	29a. Certifier (Check only one)  1 Certifyii 2 Medical	examiner: On	To the best o the basis of manner stat	examınatı	rledge, o	death occur or investiga	red at the tin tion, in my o	ne, date a pinion, de	nd place, ath occurr	and due to the	e cause(s	s) and manner as s nd place, and due t	stated. o the cause(s)
To th within	comp	Me	29b. Signature and title of certifie	7	,:				29c. Licens	e number			29d. Da	ate signed (Month,	Day, Year)
			30. Name and address of person	Jan	105	My diam	. <u>()</u>	(OD Del-1)	15	109	4-		MAF	RCH 10,	2006
1 4	A		Melecia Sant	OS M D	. 7/ 2	Mar	v1a	nd H	ealth	Cai	ce S	ystem	, Per	ry Poir	t,MD 2190
B	Sta egistra	_	31. Date filed (Month, Day, Year,	£ .	32. Registra	r's Signati	near	1/2						<del> </del>	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2<u>006</u> **Physician** Month Lloyd H. Burroughs Sr. March 11, 8:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 11/26/1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral XX**M 2□ F 214 18 8679 84 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State ir then "natural", or itema 23a or 28a-f ehow the Madical Examinar must be notified at 10d, Inside City Limits 1 ☐ Yes 3€ No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9937 Ferndale Ave. 21046 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 nd Mental Hygiene. marked other then College (1-4or 5+) Elementary/Secondary (0-12) Executive Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked of any injury or other traumatic ever William Henry Burroughs Virginia E. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E. Burroughs/Wife 9937 Ferndale Ave. Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State National Mem. Park 3/14/2006 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. Ellicott City, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNG **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): ettending physicien a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) tha Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate 1 🗌 Yes Division of Vital funaral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 3 NO မှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification; or Attending Injury 5 Pending within 24 hours efter death. To the Funeral Director: A 1 Tes 2 No investigation tha 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e MD/ 6701 32. Registrat's Signature 31. Date filed (Month, Day, Year) State MAR 13 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year **Physician** 9:44 P M 12 March 2006 Harriett L. Birx /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Abundant Life Group Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 □ M 2 X F Yrs. 101 Nov 8, 1904 Maryland Director 217 56 2487 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b County r than "natural", or Iteme 23a or 28a-f show the Medical Examinar roust be notified at 1 ☐ Yes 2 No Ellicott City MD Howard Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 9722 Hillsmere Road 21042 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ₽ No Specify: Specify: ģ 3€ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 avent, # 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any injury or other traumatic avent, size. 17. Father's Name (First, Middle, Last) Be James Combs Annie Pahl ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9722 Hillsmere Road Ellicott City, MD 21042 Anne L. Nix/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Salem Lutheran Ch. Cem. 3-16-2006 Bakersville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Introtum Myocardial **Physician** Hours /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsaquence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√ No 24a. Was an autopsy performed? has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Dother (Specifygroup home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 5 Pending investigation 1 XNatural after death.

Director: All 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Hospital 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier . M. D. 26786 March 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roesler ne , Glen Burnie, Md., 21060 M.D; 115 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Glown & Specific Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of Marylan		artment of He tificate of D			ne No 0 6	09636	
J.	2 8.	g.	Decedent's Name (First, Middle, Last)					2. Date of Death	Day	3. Time of Death	
	Physicia /Medic	A 18	Andrew Jackson				March	Month Day Year 2006 9:05			
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County o	f Death	
		gar.	7407 Quixote Co	urt			Bowie		Pri	nce George's	
1 1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country)	
	Director		579-05-6179	90	Yrs.			May 13,	1915	New Jersey	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits	
	Maryl f sho	ō	W 1 1 D-2	C 1 -		D	arri a			1 XYes 2 No	
	the t	Director	Maryland Prince  10e. Street and Number	George's	-	10f. Zip Code	owie	10g	j. Citizen of W	hat Country?	
	3a or	0	7407 Quixote	Court			20720		United States		
	72 hours after death with the Maryland inatural, or Itams 23a or 28e-f show olds Examinet must be notified a	Funeral	-	12. Was Decedent Ever in U.	S. 13.	Was Decedent of His I Yes, specify Cubar	panic Origin? (Sp	ecify Yes or No-		- American Indian,	
9	or ita		1 Never Married 2 Married	Armed Forces? 1 □X/es 2 □ No If Yes, Give			Specify:	rican, etc.)	Specify:	, White, etc. Black	
21215-0036	ours	d by	3 Widowed 4 □ Divorced	Year or Dates:		7 7 7 8 2 LANO	Specify.		Зреспу.	DIACK	
5	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done do	uring most of work		b. Kind of Bus	iness/Industry	
12	han a	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use retired)			0		
7	lled v tygie her t		17. Father's Name (First, Middle, Last)	4			Worker	e (First, Middle, Ma		overnment	
anc	ntal H	Be		C*			10. 1000101 3 11411	Sadie Wa		,	
Ž	hould d Me mark matic	2	Andrew J. Car		19b Mailir	ng Address (Street a	nd Number or Bur			State, Zip Code)	
Maryland	d 2 s th an t7 is treu		Valerie A. Cary			3		., Bowie,		0720	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Maryloa Examinar must be multified at once.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date 20	c. Location - C	City or Town, State	
ğ	ages ant of at: If i		1 ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	-	natory`or other place emorial Pa	I .	/2006	Innda	ver. MD	
Baltimore,	nit. F eartme orter injur		21. Signature of Fuheral Service Licens			. Name and Address		tewart Fu			
ä	Depa Depa Impo any i		I John T. S	Lewon X III		4001 B	enning R	d., N.E.	Wash.,	DC 20019	
	œ,		23a. Part1. Inter the disease, or complishock or heart failure. List only or	cations that caused the death	n. Do not ent	er the mode of dying	, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
	Physician		Immediate Cause (Final	Cause direactimile.	21		roles or			Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	- colp	0103 01	-			
	Examiner		Controllette for the date	).							
	D =	ner	Sequentially list conditions, it any, leading to anniediate cause. Enter Underlying	Due to (or as a conseq	usnes of):						
	cuted	Examiner	Cause (Disease or injury that initiated events								
O	e exe ien a urial-l		resulting in death) Last	Due to (or as a consequence	uence of):					4	
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	Physician/Medical		1.							
9	leath certific attending p	Me	IF FEMALE:	0. 11						-	
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3	Ectopic pregnancy			23d. Date Mon	ol delivery th Day Year	
o	at the de by the a tached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d	eath 5L	Other (specify)					
ď.	that the		Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contri	bute to the cause ol death?	
of Vital Records,	Se us	d by		, and the second				1 ☐ Yes	2 □ No	3 Probably 4 Unknown	
Ö	w requir been si should	ete			·			24a. Was an	24h W	lere autonsy findings available	
Rec	e la has	Completed						autopsy performs	pi d? de	lere autopsy findings available rior to completion of cause of eath?	
a		e Co	25. Was case referred to medical				OO Plans of Dani			□Yes 2□No	
₹	Physician: ' this certifica al director, p	o Be	eveminer?	lospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Othe	r	th <i>(Check only</i> one) ome 5 <b>X</b> Residen		r (Spacifu)	
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how			
lon	Attending I r death. sctor: After by the funer	ig l	1 ANatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		? ′es 2 ☐ No				
Division	or Attendi after death. Director: A in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, larm, st	eet, factory, office		28l. Location (Stre City or Town,	et and Numbe	r or Rural Route Number,	
Ö	pital or A ours after erel Dire filled in by	Cert	4 E Homicide	building, atc. (Spacing	<i>y)</i>			Only of Youn,	Oldio)		
	e Hospital 24 hours a e Funeral letely filled		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my kno	wledge, deat	h occurred at the tim	e, date and place,	and due to the cau	ise(s) and mar	nner as stated.	
	To the Hos within 24 ho To the Func completely f	ledical	one)	and manner stated.							
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License			_	(Month, Day, Year)	
•	5		1//		1	MU	12137		3-0	7006	
	Can		30. Name and address of person who co		n 23a) (Type,		1		100) 3	X 20010	
	ge c		Patricia DAVId 31. Date filed (Month, Day, Year)	32. Registrar's Signa	(UG	trung;	St NW	HILD	1.15%	L 00010	
1	Sta Regist		MAR 1 4 2006	en H lo	and !	-					

	L745		Please	Type or Print in Black		-	•							
KG			For Stete Registrer		partment of Health and M ertificate of Death	ental Hygier Reg. N	2004 00697							
	Physici	an	1. Decedent's Name (First, Middle, L	ast)		2. Date of Death Month	3. Time of Death							
-	/Media	al	CATRICE	CRUSOE		March 11								
	Examir	er	4a. Facility Name (If not institution, g Prince George's	Hospital Center	4b. City, Town, or Location of Death Cheverly	]	Prince George's							
	Funeral			Sex 1	Months Days Hours Min	8. Date of Birth (Month, Day, Yea MAY 28 19	9. Birthplace (State or Foreign Country)							
	Director		578-98-3080 Usual Residence of Decedent	20 113		MAY 28 19	77 MARYLAND							
	nylanc how		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits							
	Sa-f.	ctol	MD PRINCE	GEORGE'S LANDOV	ER		1 A Yes 2 No							
	or 24	Dire	10e. Street and Number	, DOAD # 102	10f. Zip Code	10g. (	Citizen of What Country?							
	• 23a	rai	3301 DODGE PARK		20785		U.S.A.							
36	72 hours atter deeth with the Maryland natural', or Iteme 23a or 28a-1 ehow dical Examinar must be notitled at	by Funeral Director	11. Marital Status  1 ⚠ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ₹ No If Yes, Give	<ol> <li>Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecrfy Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK							
8	tural	edt	15. Decedent's	Year or Dates:	cedent's Usual Occupation	16h	Kind of Business/Industry							
21215-0036	l within 72 iene. r than "ne the Medis	Completed	(Specify only highest g	(G College (1-4or 5+)	ive kind of work done during most of worki e. DO NOT use retired) INSURANCE CLERK	ng	PRIVATE							
and 2	id be filed ental Hyg ked other c event,	To Be C	17. Father's Name (First, Middle, Last UNKNOWN			(First, Middle, Maid								
Maryland	permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show way injury or other traumatic event, the Madical Examinat must be notified at once.	1	19a. Informant's Name/Relationship SHARI J. CRUSO	1 11 1	ailing Address (Street and Number or Rura D1 DODGE PARK RD #									
Baltimore,	ages 1 au ent of Hea nt: If Item y or othe		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  RESURRECTION CEME. 3/18/06 CLINTON, MARYLAND  21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. JENKINS FUNERAL HOME											
Ħ	ortan													
ä	Depermit Depermit Impor eny ir		* L. D. Mahall 7474 LANDOVER ROAD LANDOVER, MARYLAND											
	Physician /Medical	•	23a. Part1. Enter the disease, or co- shock, or heart fajfure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do not by one cause on each line.  a. DCCLUSCULT	enter the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death							
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	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Left Legt	vacture									
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	tificate g physi as the b	dica	•	d										
P.O. Box 687	ne death cer the ettendir hed for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ◯ Unknown		3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year							
	signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to											
Records,	e faw requir has been si je 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
<u>=</u>	ysician: The la is certificete has director, page 2					performed? 1 Yes 2 ☐ f								
Κ	Physician: this certifice ral director, p	Be	25. Was case referred to medical examiner?  12∑¥es 2 □ No	Hospital:	26. Place of Death									
ō	F = E	2	27. Manner of Death	28a. Date of Injury 28b. Time	tient 30 box 40 Nuising not	ne 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify)							
Division of Vital	Attending Phy it death.  ctor: After this by the funeral c	tior	1 □Natural 5 □ Pending 2 🗙 Accident investigati	(Month, Day Year) Injui	28c. Injury at y Work?  1 □ Yes 2 ☑ No	Subjec								
vis	Attendii er death. ector: A by the fu	ILIC	3 Suicide 6 Could not 4 Homicide determine	be One Diese of Joines At home for		28f. Location (Street	and Number or Rural Route Number.							
Ö	tal or rs efte al Dir	Certification:		www.	<b>√</b>	City or Town, Sta	Luown							
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying F (Check only one)	Physicien: To the best of my knowledge, di eminer: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)							
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29d. (	Date signed (Month, Day, Year)							
	D			accompleted cause of death (Item 23a) (Ty)	O.C.M.E.	Ma	arch 11, 2006							
K	2		CAROLIT. ALL		Penn Street, Baltim	ore, Mary	land 21201							

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 4 2006

. Registrar's Signature

		ŀ	1 - For State Registrar	State of Marylan		it of Health and Ne of Death	Mental Hygier		9638
	P 25	<u>st</u> (5)	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physic		Ronald Caldw	7e11			MARCH	12,2001	1230 PM
	/Med Exam		4a. Facility Name (If not institution, give str	reet and number)	4b. City,	Town, or Location of Death	1	4c. County of Death	
	LAdill	ii ici	Doctor's Hospital		La	nham		Prince Geo	orges
	Funera	ı	5. Social Security Number 6. Sex	7. Age (In yrs.	(ast birthday) If Under	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthpl Count	ace (State or Foreign try)
	Directo		578-82-8932 <sup>1</sup> 121	M 2□F 3	6 Yrs.	Day's Flours Wills	May 13,		ins, S.C.
	P		Usual Residence of Decedent	100 6	y, Town or Location			10	Od. Inside City Limits
	trylar show		10a. State 10b. County  Maryland Prince Ge		eenbelt				1 √ Yes 2 □ No
	n the Maryland r 28a-f ehow	Funeral Director	•	eorges or		0.4	100	Citizen of What Coun	10/2
1	or 2	D I	10e. Street and Number			p Code			
17.	ath v	9	9314 Edmonston Road			20770		nited Stat	
3	er de	nue		2. Was Decedent Ever in U. Armed Forces?	If Yes, spe	dent of Hispanic Origin? (S scriy Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	etc.
ā	36 s after	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 ★No If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: Bla	.ck
ALDWE ALDWE	5-0036 72 hours after death w netural; or Itema 23a		15. Decedent's Educa		16a. Decedent's Usu	al Occupation	165	. Kind of Business/Ind	lustry
N.	215 Ithin 72 Medical	olet	(Specify only highest grade	completed)	life. DO NOT L				
0	d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. Phygiene. sther than "natural", or Itema 23e or 28e-f show only, the Medical Examiliser wast be inclified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Corpora	te Trainer		Private	
	d Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	
0	Red be	To B	James Caldwell			Essie	Mae Rogers		
1	Maryland 2: the street of the		19a. Informant's Name/Relationship (Type	e, Print)		s (Street and Number or Ru			Code)
CONAL	6 4 6 5		James Caldwell /Fa			nston Rd.# 1			.0770
_0	Baltimore, Permit. Pages 1 an Department of Hea mportant: If item	П	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	Place of Disposition (Na cemetery, crematory or	other place)	Date 200	c. Location - City or To	wn, State
K	Baltimor permit. Pages Department of Important: If it		4 Donation 5 Other (Specify)		aryland Nat		/2006 La	ure1, Md.	
	Balt permit. Departr Importa	ouce.	21. Signature of Funeral Service Licenses	9	22. Name a	and Address of Facility	e Euneral	Homes . P.A	4.00-1-
	0 897	5	Mitta /su	ved_	5538	ander S. Pop Mariboro Pi	ke/Forestv	ille,'Md.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat e cause on each line.	h. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,	0	Approximate Interval Between Onset and Death
	Physicia	n	Immediate Cause (Final disease or condition	Agus ver	Finer	deficers	Sindron		10415
	/Medica		resulting in death)	Due to (or as a consec	uence of):				U
	Examine		Sequentially list conditions. b.	Dehyde	low				
	D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b.	Due to (o /s a consec	uence of):				
	and and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	mence ot).				
	760, te be execu ysicien and ie burial-tra		and the second s	Due to (or as a corisec	dence ory.				
	876 sate to shysic	dicai	d.						
	BOX 68' death certificat e attending phy d for use as th	₩.	IF FEMALE:	Bc. If yes, outcome of pregn.	ancy			23d. Date of delive	201
	Box eath cert attending for use a	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3 Ectopic			Month Month	Day Year
	O. In the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ieatii 5 🗆 Otiiei (s	specify			
	cords, P.O. Box 68760,  **requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit.	by Physician/Med	Part II. Other significant conditions conf	tributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
	d sign			· ·			1 ☐ Yes	2 □ No 3 □ Prob	ably 4X Unknown
	Orc requ	Completed					24a. Was an	24h Were auto	psy findings available
	Rec The law ite as b	ldu					autopsy	prior to co death?	mpletion of cause of
	The the cate	S					1□ Yes 2	No 1□ Yes	2 No
	of Vital Re Physician: The I	Be	25. Was case referred to medical examiner?	ospital:		Othor	eath Check only one		
	Of Phys this dirties al dirt	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 V Inpatient 2L	ER/Outpatient 3 0	JOA 4 INUISING	Home 5 ☐ Residence 28d. Describe how	ce 6 ☐Other (Specifinium occurred)	y)
	Juner funer	0	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		1- 7	
	ISIC Iten death tor:	cat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h			28f. Location (Street	et and Number or Rura	al Route Number,
1	Division of Vital Records, to Attending Physician: The law requires that death. Director: After this certificate las been signed in by the funeral director, page 2 should be come.	Certification:	4 Homicide determined	building, etc. (Speci	(ty)	,,	City or Town,		
	pital ours and filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, death occurre	ed at the time, date and place	e, and due to the cau	se(s) and manner as s	stated.
ľ	Division of to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical Examinone)	ner: On the basis of examin and manner stated.	ation and/or investigation	on, in my opinion, death occ	curred at the time, date	and place, and due to	o the cause(s)
	o the	Me	29b. Signature and title of certifier		2	9c. License number	290	. Date signed (Month,	Day, Year)
	- 3 - 0		ATD anno	7	_	D53118		3/13/01	6
	00		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Print)	25-115		- 1	
	CK (3)		Thomas Hansson, MD		Luck Road	Lanham M	D 20106		1.
		- 1	31. Date filed (Month, Day, Year)	Begistrar's Sign	atura				
Š	10.00 Mg 1, 100 T	State	MAD 1 5 2006	A. Niegistian o eigi	diam's				

			_ For	State of Ma		/ Depa	artment of H	lealth and	•		000	00700	
			1 - State Registrar			Cei	tificate of	Death		Reg. No.	JUb	09639	
	Dhysiai	() an	Decedent's Name (First, Middle, Las.	"					2. Date of De Month	eath Day	Year	3. Time of Death	
	Physicia /Medic		Maywood	Belvie	Cı	coss			March	11,		11:50 P. <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of De	ath	4c. (	County of Dea	ith	
			Collingswood Nursi	ng Center			Rockvil	L1e			iont gon	nery	
4	Funeral		5. Social Security Number 6. Se		(In yrs. las		If Under 1 Year Months Days	If Under 24 H Hours M		rth ay, Year)	9. Bi	rthplace (State or Foreign ountry)	
	Director		212-24-4021	JM ZAJF	98	Yrs.			April	7, 19		ryland	
7	. *		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits	
2	eho	5										1 ☐ Yes 2 🛣 No	
2	8e-1	ecto	Maryland Montgome  10e. Street and Number	ry	Roc	kvil.							
de de la	De C	급					10f. Zip Code	_		10g. Citiz	en of What C	ountry?	
t d	s 23	ral	4508 Bayne Street	40 11/2 10 11/2		10	2085				USA		
5	Ter I	nu	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Wh</li> </ol>		
2 2	, 0,	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10		1 ☐ Yes 2X No	Specify:			Specify:	· · · · · · · · · · · · · · · · · · ·	
3 3	tura	edi	15. Decedent's Ed			f6a Dece	dent's Usual Occup	ation		16h Kin	nd of Busines	White	
2 5	landing in	olet	(Specify only highest grad	de completed)		(Give	kind of work done DO NOT use retired	during most of v	vorking	100.10	14 01 04311163.	sindustry	
	tha	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	F	agger			Sna	ck Foo	d Company	
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8 3	ked ked	0 8	Richard T	nomas Dule	v				Mamie	Del	Delight		
dely all de La La La Coool	mar mar	-	19a. Informant's Name/Relationship (7		-	19b. Mailir	ng Address (Street	and Number or		-		Zip Code)	
\$	alth a 27 le		Faith E. McGowan/N	itece			enham Roa						
ב ב	oth e d		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of		Date		cation - City o		
2 3	S E E E		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				natory or other place	1	115/2006	D 1-		Manusland	
	artmoortan ortan Injur		21. Signature of Funeral Service Licens		Parki		Mem. Park 2. Name and Addre					Maryland	
ם פ	popular reason tailed a should be marked to the state of the state of the should be popular to the should be should be should be shown any interest if it is a 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		Murchano	Mlno	elen							MD. 20877	
	,Au		23a. Part1. Enter the disease, or comp	lications that caused	the death.						, Durg,	Approximate	
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lir	10.		•					Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	a Congesti			ailure						
	xaminer			Due to (or as		nce of):							
	7.8	ē	Sequentially list conditions, if any, leading to immediate	b. Breast C		nce of):							
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be executed	al-tra	xa	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):							
	ysicial ne buri	call		d									
	phy s the			d									
<b>4</b>	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of de	alivery	
<b>ء</b> בُ	atte	cla	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)	/		-	Month	Day Year	
į į	y the	lsk	9 Unknown	9□ Unknown			., ,, ,, _						
۳ او ا	ned b		Part II. Dther significant conditions co	ntributing to death bi	ut not resulti	ng in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco us	se contribute	to the cause of death?	
3	sign d be	d by							1 🗆	Yes 2	]No 3∏F	robably 4 🖾 Unknown	
5 5	shou	Completed							24a. Was	s an	24h Ware s	utopsy findings available	
2 9	s has	F							- auto		prior to death?	completion of cause of	
<b>5</b> 2	r, pa		25. Was case referred to medical						1 ☐ Yes	2 🔀 No		s 2□No	
, i	er death.  Pot the funeral director, page 2 should be detached for use as the	o Be	eyaminer?	Hospital:	-5-		oth	000	Death (Check only				
5 8	r this	<del> </del>	27. Manner of Death	28a. Date of Injur	nt 2 EF	Outpatier  b. Time o	" O DON	7 63 11013111	g Home 5 Res		<del></del>	ecify)	
֝֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Afte fune	ţ	1 Natural 5 ☐ Pending	(Month, Da)	Year)	Injury	Wor	k? Yes 2 □ No	200. 2000.00	now injury	00001100		
2 5	deal ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be		urv - At home	e. farm. str	reet, factory, office		28f Location	(Street and	Number or F	Rural Route Number,	
	Dir.	Certification:	4 Homicide	building, etc	c. (Specify)				City or To	wn, State)			
e e	nours noral		29a. Certifier 1  Certifying Phy	sician: To the best	of my knowle	edge, deat	h occurred at the tir	me, date and pla	ace, and due to the	Cause(s)	and manner a	is stated	
3	24 h etely	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination	n and/or in	vestigation, in my o	ppinion, death or	courred at the time	, date and	place, and du	e to the cause(s)	
400	To the Function of the death.  To the Function of the death.  To the Function of the difference of the death of the difference of the diff	Me	29b. Signature and title of dertifier	$\Lambda$			29c. Licens	se number		29d. Date	signed (Mor	nth, Day, Year)	
	3			$\mathbb{V}$ 1	1		11 ~	0512	0 -		3-13.	-61-	
			30. Name and address of person who	ompleted cause of d	eath (Item 2	3a) (Type		0217	00		> 10.	- J-	
			Anushiraven Dadgar					Dr., #	201, Roc	kvill	e, MD.	20850	
<b>5</b>	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signatur		had ?		<del>-</del>				
			WAK I/	7111114	4.0	er a	TABLES !						

hysici	an	1 - State Registrar AMEND#8&2010001  1. Decedent's Name (First, Middle, La HAROLD J. C							Date of Dea Month arch 1		006 Year	3. Time of 2:20	
/Medic	al	4a. Facility Name (If not institution, giv			4h Cit	v Town or	Location of I			_	County of Dea		
Examin	er	Rockville Nursing				kvill		Dod.iii			ntgome		
uneral rector		Social Security Number 6. S		(In yrs. last birthda 89 Yrs.		er 1 Year	if Under 24	Hrs. 8. Min.	Date of Birth (Month, Day ay 15	(Year)	9. Bir Co	thplace (State of ountry) ZONA	or Fore
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location			1				10d. Inside C	ity Limi
aho ad al	ō		2.16.17	Gaithers								1 🗆 Yes	
28e-f	Director	Md. Montgome	er y	Galther		ip Code			-	10g. Citiz	ten of What Co	ountry?	
Se of	<u>a</u>	5 Green Watch Co	ırt				878			Uni	ted St	ates	
ms 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	. Was Dec	edent of H	spanic Origin	n? (Specif	y Yes or No-	1	4. Race - Ame		
Important: If item 27 is marked other than "natural", or Itams 23s or 28e-1 show any injury or other treumatic event, the Madical Examiner must be natified at 00cs.	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	WWII		2(XINo		Puerto Nic	an, etc.)		Black, White Specify:	White	
natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Us	ual Occupa	ation during most o	of working		16b. Kir	nd of Business	/Industry	
the M	mc	Elementary/Secondary (0-12)	College (1-4or 5-	-)	esman	200 / 01// 02	,			Spi	rits		
other ant, it	ပိ	17. Father's Name (First, Middle, Last	)				18. Mother's	s Name (F	irst, Middle,				
o pes	To Be	Harold J. Collin	ns				Haze	1 May	y Buil	derb	ack		
mar	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Addre	ss (Street	and Number	or Rural F	loute Numbe	r, City or	Town, State,	Zip Code)	
27 ls r treu		Don Collins (Ne	phew)	5 G:	ceen '	Watch	Court	Ga	ithers	burg	, Md.	20878	
ma to		20a. Method of Disposition	70	20b. Place of Dis	position (N	ame of r other plac	(a) M			20c. Lo	cation - City or	Town, State	
P S		1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		Live Oa				larch 2006	<del>10</del> ,	Cha	rlesto	n S.C.	
Importa any inju pnce.		21. Signature of Funeral Service Lice	nsee A						ol Fun			Md. 208	77
_ = u		PACIFIC AL	polications that caused								Dulg,	Approximat	
sician		23a Part 1 Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a.Hypertens									Interval Bet Onset and	Death
edical miner		resulting in death)		consequence of):									
30	_	Sequentially list conditions,	b Chronic R	enal Fai.	lure								
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	.Coronary		icane	0							
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sicier buri	cai		Dementia										
phy:													
anding use a	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 DEctorio	pregnancy				2	23d. Date of de		
ed by the attending physicien and detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐ Pregnant at 1		5 ☐ Other						Month	Day	Year
igned b	y P	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying	g cause giv	en in Part I.		23e. Did to	obacco u	se contribute t	o the cause of	death?
n sign									1 🗆 Y	'es 2[	□No 3□P	robably 4 🗹	Unkno
s been si	Completed								24a. Was		24b. Were a	utopsy findings completion of c	availa
page 2	mo							_		rmed?	death?	_	Jause (
certificate rector, pag	a	25. Was case referred to medical				15.053	26. Place of	of Death (	Check only o				
	OB	examiner? 1 Tes 2 No	Hospital: 1 Inpatier	sing Home	5 🗆 Resid	dence 6	6 □Other (Spe	ecify)					
ter this neral di	n: T	27. Marrier of Death 1 V Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur		28c. Injur Wor	y at k?	28	28d. Describe how injury occurred				
To the Funerel Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	Yes 2 □ N		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Funerel Diely filled is	edical Ce	(Check only 2 Medical Exa	hysician: To the best o miner: On the basis of	examination and/or	ath occurr investigati	ed at the tir	me, date and pinion, death	place, an	d due to the	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	(s)
the I	Med	one)  29b. Signature and title of a rtifier	and manner sta	led.	T.	29c. Licens	e number		-	29d Dat	e signed (Mon	nth. Dav. Year)	
2 8		34	west V	PUXEPL		D004					h 13,		
		0000	CULCUS W	now for		2304			1		,		
4		30. Name and address of person who	completed server of the	ath /Itam 22-1 /T	o Print								

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death dent's Name (First, Middle, Last) CHING **Physician** MARCH 2006 /Medical me (If not institution, give street and number)
TOHNS HOPKINS HOSPITAL HAT MORE ( 4c. County of Death Examiner Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Korea 1 ★M 2 ☐ F 83 071-52-8763 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Olney 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2100 Olney Sandy Spring Road 20832 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. I other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Asian δ If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kisup Chung Kannan Chang 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Lee/Daughter 19 Turnham Court Gaithersburg, Md 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem 3/14/06 Silver Spring, Md 21. Signature of Funeral Service Licenses PHILIP D. RINALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VAL FAILUNE **Physician** UNICHDIU M resulting in death) /Medical Examiner KEURRENT METASTATIC REMAL CELL CARCINOMA UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and if for use as the burial-transit UPPER GASMOINTESTINAL BUTEDING DAYS resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy perform certificate 1 Yes 2LXNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \tau \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 **X**No 1X Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident Funeral Director: stely filled in by the 6 □ Could not be 3 🗍 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P18620 Jawali Jaranella, Medical Doctor MARCH II 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAWALI JARANILLA, THE JOHNS HOKINS HOIPITAL, 600 NOTH WOLFE STREET BALTMORE, MARYLAND 21227

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

14 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registra MEND#16aperFH3/14/06, EMW, McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 00: 50 A M March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GROVE ROCKVILLE, MAK
If Under 1 Year If Under 24 Hrs.
Hours Min. HOVENTIST MARYLAND MONTGOMERY 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□F Months Hours None Yrs. Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County "natural", or Itams 23a or 28a-f show 1 ☐ Yes 2 No RINCE Completed by Funeral Director UEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No Specify. 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) INFAN None None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANDELARID EUZABETH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -ORDHAM STREE Department of Health Important: If item 27 MOTHER LUZABETH LOPEZI other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 3/16/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22 Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 21. Signature of Funeral Service Licensee Ca ◢. 23a. Part1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Spiratory Physician 24 days disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Box 68760. physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by failu 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 200 1 Yes Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Propatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a

Division of Vital Records.

State Registrar

To the I

Medical

29a. Certifier

(Check only one)

29b. Signature and title of pertifier

VESLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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2. Registrar's Signature

MD

5GAH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061670

9901

29d. Date signed (Month, Day, Year)

March

Medical Drive Rockville

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stote Registrar per physician 3/15/06 WCHD Certificate of Death D.H. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Ε. COBB MARCH 10, 2006 3:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DELMAR WICOMICO 211 EAST SPRUCE STREET If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Min 1 □ M Director 221-16-3012 2-8-1926 DELAWARE Usual Residence of Decedent the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No WICOMICO Director DELMAR MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Exeminatinal Le 300 POPLAR STREET 21875 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2 f Yes, Give 2 👿 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ♥ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FARMER** POULTRY 12 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELMER PARSONS IDA HITCHENS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 or other tri KAY PIANKA-DAUGHTER 203 HANTWERKER DRIVE, DELMAR, DE 19940 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State PRINCE GEORGES ther place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 3-14-06 DAGSBORO, DELAWARE 21. Signature of Funeral S 22. Name and Address of Facility MELSON FUNERAL SERVICES Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. That only one cause on each line. FRANKFORD, DELAWARE 19945 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease Immediate Cause (Final disease or condition resulting in death) Physician Chronic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 4 Pregnant at time of death P.0. 9□ Unknown 9 Unknown ģ signed b i be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Unknown 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy performed 2 🗆 No 2/2 No 1 Yes or Attending Physician: care giver's home 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ို 1 🗌 Yes 2 No 3□ DOA 4 ☐ Nursing Home 5 Hesidence 6 🖾 Other (Specify, funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a
To the Funeral I
completely filled 29a. Certifier 🗲 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and on who completed cause of death (Item 23a) (Type, Print) and address of pers (3 Y P) nicion 0 Day, Year egistrar's Signature 31. Date filed (Month. State MAR 15 2006 Registrar

1 _ For State	State of Maryland / Department of Health and Mental H	ygiene n9644
Registrar  1. Decedent's Name (First, Middle	Certificate of Death	Reg: No. 3. Time of Death
Physician	Month	Day Year
/Medical Examiner  4a. Facility Name (If not institution	give street and number)  4b. City, Town, or Location of Death	4c. County of Death
ManoK:	N MONOR PriNCESSANNE	. Somerset
Funeral 5. Social Security Number	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of E	Birth Jay, Year)  9. Birthplace (State or Foreign Country)
Director Usual Residence of Decedent	X 10-	2-34 UH.
2	10c. City, Town or Location	10d. Inside City Limits
in i	ester Pocomoke	1 Yes 2 □ No
et to a local street and Number	10f. Zip Code	10g. Citizen of What Country?
	Street New towns 21831	U.S.H.
in E in 1 M Nover Married 2 Marr	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
2 Should be filled within 72 hours atler and Manna Hygield within 72 hours at and Manna Hygield within 72 hours atler and Manna Hygield within 72 hours atler and Manna Hygield.  2 Should be filled within 72 hours atler and Manna Hygield.  3   Midowed 4   Divorced (Specify only highest	1  Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:	Specify: Blast
should be filled within 72 hours	t grade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Pa. 1. P.
N pool 17. Father's Name (First, Middle,	Last) Computar Compicion  18. Mother's Name (First, Midd	le, Maiden Surfame)
Media be with the second of th	Christonhas Lega R	065
19a. Informant's Name/Relations	19b. Mailing Address (Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)
To Maryland Ment of the mark o	1 1000 NE 125 4 TITLIEST DITUE 100	wChurch, V9.23415
20a. Method of Disposition  1 風 Burial 2 □ Cremation  1 回 Donation 5 □ Other (S)		20c. Location - City or Town, State
Baltimore, Maryland 21215-0036  Bearmit. Pages 1  Baltimore, Maryland 2  Bearmit. Pages 1  Bearmond of beating as should be filled within 72 hours at 12 mortal and 12 bearmond of leath and 27 is marked only highes 15. Decedent, It is maryland 15. Decedent (Specify only highes 15. Decedent in the marked only highes 15. Decedent (Specify only highes 17. Father's Name (First, Middle, 17. Father's Name (First, Mid	TOP STORE CERTIFICATION	Horntown, UA.
Solution of Disposition  1		Smith Toward Home
- Taken	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory only one cause on each line.	
Immediate Cause (Final		Interval Between Onset and Death
/Medical resulting in death)	a. END STAGE RENAL DISEASE  Due to (or as a consequence of):	7EARS
Examiner Sequentially list conditions	b. DIAKETES MELLIONS TYLE IT	YEAR S
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause Obsease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):	
The law requires that the death certificate be executed by the attending physician and the has been signed by the attending physician and the has been signed by the attending physician and the has been signed by the attending physician and the has been signed by the attending physician and the hast 15 months?    In		
ilicate ilicate edic		
PAYS   Charging light and the condition of the condition	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery
in the past 12 months?	4 Pregnant at time of death 5 Other (specify)	Month Day Year
O e that the second sec	ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	I tobacco use contribute to the cause of death?
Part II. Other significant conditions of the significant condition		Yes 2 No 3 Probably 4 Uknown
as ben signe 2 should be order of the standard be order of the standard ben signed by the standard benefit ben	TO VASCULAR PISEASE 24a. W	
The law requires the law requirements the law req	aul pei	opsy prior to completion of cause of death?
To the second se	1 ☐ Yes 26. Place of Death   Check onli	2 No 1 Yes 2 No
e saminer?    Signature   Sig	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Re	
Olivision or Attending Physician: The affect death.  Director: Affect death.  Director: Affect disconnected by the function of	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describ	a how injury occurred
O	ation M 1 Yes 2 No	
Division  Division  Certification  Certification  Division  Division  Certification  Certificati	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	(Street and Number or Rural Route Number, own, State)
Te to	g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
D (Check only 2   Medical	Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e, date and place, and due to the cause(s)
29b. Signature and title of certifie		29d. Date signed (Month, Day, Year)
List	7 100 62916	MARCH 13, 2006
30. Name and a dress of person	who completed cause of death (Item 23a) (Type, Print)	
24 Data filed (Marth Day Vand	20 Project Circums	11. 10 10 10 10 10 10
Registrar MAR 1 5	2006 Been & Spelis	

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State of Maryland / Department of Health and Mental Hygiene () () 09645 State Registrar item #26, per/physician, Certificate of Death 3/16/06, E. Tabe. No. Amended 2. Date of Death 3. Titee of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** March 12,2006 9:20 AM Ruth Wingate Carney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 10005 Mill Pond Dr. Bishopville Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F 88 Yrs. 186-16-1091 Director 1/17/1918 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10005 Mill Pond Dr. US 21813 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status r then "naturel", or Items the Madical Examiner :filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 XWidowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Worker Oil Company 12 .. Pages 1 and 2 should be filed w tment of Heelth and Mental Hygie tent: If Item 27 is marked other t jury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rebecca Pinkerton Jones Maurice Wingate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heelth ar Importent; if Item 27 ie eny injury or other treu once. Helen Welc 53 Dresner Circle, Boothwyn, PA 19061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 3-16-2006 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, Maryland 21811 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** oravar /Medical Due to (or as a consequence of): Examiner sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 Yes 2 X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence W Other (Specify) Hospital: ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 11X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-13-06 D27993 Jalus 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Waters, M.D. 1001 Philadelphia Ave., Ocean City, Md. 21842 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 1 6 2006

		1 - State of Maryland / [	Department of Health and M Certificate of Death		ene 
Physicia	4	1. Decedent's Name (First, Middle, Last) Francis Wright Cole		2. Date of Death Month Mar.	Day Year 3. Time of Death 7:20p M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	na.	4c. County of Death
		Madison Bay Hunt Club	Madison		Dorchester
Funeral Director		5. Social Security Number  216-40-8444  6. Sex 1 ☑ M 2 ☐ F  7. Age (In yrs. last bit) 62	thday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	
		Usual Residence of Decedent		Jun. 6,	
anylar show	5	10a. State 10b. County 10c. City, Tow MD Worcester	n or Location Ocean Pines		10d. Inside City Limits 1 ☐ Yes 2€ No
the N 28e-f	Director	10e. Street and Number	10f. Zip Code	10	lg. Citizen of What Country?
th with	ai Di	1 Arcadia Court	21811		USA
tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
burs after death with the Marylan rair, or items 23e or 28e-1 show	by F	1 ☐ Never Married 2 ② Married 1 ☐ Yes 2 ☑ No If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ▼ No Specify:		Specify: White
72 hours netural',	ted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working)	1	6b. Kind of Business/Industry
vithin ne hen	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)  Postal Inspector		U.S. Post
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Jid be Jid be Jic ever	o Be	Harold Martin Cole, Sr.	Bethyl W	right	
		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street and Number or Rura	l Route Number,	City or Town, State, Zip Code)
es 1 and 2 of Health item 27 i		20a Method of Disposition 20b. Place o	Arcadia Court, Ocean f Disposition (Name of		MD 21811 0c. Location - City or Town, State
		Cemete	ry, crematory or other place)   Mar.	13.	Orrtanna, PA
permit. Page Department of Importent: If any injury or		21. Signature of Foneral Service Licensee	22 Name and Address of Eacility		na Park Funeral Home
88188		Somes En Lawrence	495 GOV. RITCINE HW	y, Sever	na Park, MD 21146
		23a art1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List on the cause on each line.  Inmediate Cause (Final			st, Approximate Interval Between Onset and Death
Physician /Medical		disease or or ndition resulting in death)  Due to (or as a consequince	OCAROUZ INFARC	77810	
Examiner					
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that the death certificated by the attending problem of the asset of the second of the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery  Month Day Year
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ysicie is cert directe	To B	examiner? 1   Yes   2   No	Other		YOther (Specify)
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ttendi death. stor: A	icati	2 Accident investigation	M 1 Yes 2 No	P8f Location (Stre	eet and Number or Rural Route Number,
after Direct	Certification:	3 Suicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ann, street, ractory, onlos	City or Town,	State)
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	dical C	29a. Certifier Certifying Physician: To the best of my knowledg			
the H hin 24 the F	Medi	one) and manner stated.			
5 with 5		Mismis Walse MD	023867		3-8-06
		29b. Signature and title of certifier  The May Walsh MD  30. Name and address of person who completed cause of death (Item 23a)  7HOMS WALSH MD 130 Love Abt  31. Date filed (Month, Day, Year)  22. Registrar's Signature	(Type, Print)  At Roan Sterious Pirit	LOMO S	21666
Sta	to	31. Date filed (Month, Day, Year) 2. Registrar's Signature	A	7	+ 7
Registr	ar	31. Date filed (Month, Day, Year)  MAR 1 3 2006  2. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** a M Barbara Crowell March 2006 9:30 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6011 Herring Bay Road Deale Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 5, Oct. 1918 Minnesota 87 342-38-6917 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Worde ! r than "nature!, or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2X No Anne Arundel Deale Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6011 Herring Bay Road 20751 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White Baltimore, Maryland 21215-0036 ģ 3XXWidowed 4 ☐ Divorced eted 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Compl other than Elementary/Secondary (0-12) College (1-4or 5+) Teacher Secondary Education 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if item 27 is marked oth eny liquy or other treumatic event pixe. 17. Father's Name (First, Middle, Last) Chester A. Shafer Gladys Maine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Torgerson (Daughter) 6216 Wewll Drive, Tracys Landing, MD 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State 3-11-2006 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Foneral Service Licenses 12 Ridgely Avenue, Annapolis, MD 21401 Jai Approximate Interval Between Onset and Death 23a. Part1. Enter the "bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart millure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 -Cig Denron Physician Cherry /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes 2 No 1 ☐ Yes 2 No 1 Tyes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 : After this certific funeral director, Hospital or Attending death. the Director:

in by

Completed Be ို Certification:

Medical

1 Natural 2 Accident 3 🗌 Suicide 4 Homicide 29a. Certifier

25. Was case referred to medical examiner?

1 Tes 2 No

27. Manner of Death

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be

29c. License number 0040519

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one,

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 3/10/06

28l. Location (Street and Number or Rural Route Number, City or Town, State)

09641

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

1401 Madison Park Drive, Glen Burnie, MD 21061 Mirza Nusairee, MD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State Registrar 31. Date filed (Month, Day, Year)





within 24 hours a To the Funerel C

State of Maryland / Department of Health and Mental Hygiene 09648 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Year 03/10/2006 6:30 A M Margarita R. Clements /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Spa Creek Nursing Home Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 89 215-05-3491 12/12/1916 Puerto Rico Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or items 23s or 28s-f show the Modical Examiner must be notified at XXYes 2 □ No Harrison Pass Christian MS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 410 St. Louis Street 39571 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: Puerto Rican Baltimore, Maryland 21215-0036 ¹XXYes 2□ No Specify: White ۾ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Customs Agent 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny jiny or other traumatic event page. 17. Father's Name (First, Middle, Last) Be Mary Antonia Quinois Joseph Angel Ramirez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Ladner/ Niece 8637 Cleo Smith Road Pass Christian, MS 39571 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garden of Memories 3/21/06 4 ☐ Donation 5 ☐ Other (Specify) Metairie, LA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subor **Physician** uk /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ፩ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 2 | No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 Tes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 29a. Certifier Emertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 32136 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2108 Did one Drive Cher 200 31. Date filed (Month State Registrar

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	State of Maryland / Department of Health and M	Mental Hygiene 🕕 🖟	09649
	Certificate of Death	Reg. No.	

		•	For State Registrar	State of Ma	-	partment of H <i>ertificate of I</i>			eg. No.	UYb49
	Dhuniai		Decedent's Name (First, Middle, La	st)				2. Date of Dear		3. Time of Death
	Physicia /Medic		John Dalton		, Jr.		1	MÄRCH	13, 2006	10:20A. M
*	Examin	er	4a. Facility Name (If not institution, giv 19406 SANDY LAKE 1				Location of Death CRY VILLA	GE	MONTGOMER	
é	Funeral Director		212-78-3290	Sex 7. Age 1⊠M 2□F	(In yrs. last birthd	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) July 20	, Year) 9. Bird Co , 1957 Mar	hplace (State or Foreign untry) Yland
	land Dw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary In I	tor	Maryland Montgo	nery	Montgo	mery Villag	ge			1 ☐ Yes 2 🔀 No
	ith the	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	e 23s	eral	19406 Sandy Lake	Drive	ver in II S		0879	acify Yes or No-	United Sta	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow enty injury or other traumatic event, the Modical Exaction must be rectified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 🛣 N  If Yes, Give  Year or Dates:	0	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	
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Registrar

		Registra Amend Ttem:  1. Decedent's Name (First, Middle, L.		1.0071	11.201	ggifigente of			2. Date of De Month	Day	Year	3. Time of Death
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0	To Be	Leor	ard Clo	ud					Cynth	ia Ki	.ng	
item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ng Address (Street	and Numbe	or or Rura	I Route Numb	er, City or T	Town, State, Zip	Code)
er tra		Alonzo W. Cloud,	Jr.	(son)		Wells Cam	ip Roa					
or oth		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3	☐Removal from		Place of Disp cemetery, cre	osition (Name of matory or other pla			ate	20c. Loca	tion - City or To	wn, State
jury		' 4 ☐ Donation 5 ☐ Other (Spec	cify)	Ţ		emetery		03/1	7/06	Elkt	on, Mar	yland
Important: If is any injury or o once.	1	21. Signature of Funeral Service Lig	ALLEN	m dr	L	<ol> <li>Name and Addresse</li> <li>Pat</li> </ol>	terso	n &	Son Fur	eral	Home, F	P.A.
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		shock, or heart failure. List on Immediate Cause (Final	ry one cause on	each line.			3.		,	·		Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March **Physician** 2006 Shirley Winton 10:07PM DuBree /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sax 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 25F 68 Director 220-34-5113 1937 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. 3808 Wilkinson Road 21078 238 Funeral or iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Cosmotologist alth and Mental Hygier 27 ie marked other the ir traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be Ida Thompson Daniel Rudisill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health an Important: if item 27 is eny injury or other trau 3808 Wilkinson Rd. Havre de Grace, MD 21078 Robert A. DuBree (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, MD Harford Mem. Gdns. 3/25/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Tarring-Cargo Funeral Home, P Aberdeen, Maryland 21001-3399 mar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSCLERDTIC CARDIO VASCULAR
o (or as a consequence of):

DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate eause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclen end for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 ☑ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٢ 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner-of Death 28d. Describe how injury occurred Certification: To the Hospitei or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a

To the Funerel I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1903 MARCH 22, 2006

Registrar

DHMH 17 Rev 1/2001

State

HAL

32. Registrar's gnature

SOUTH UNION AVE,

31. Date filed (Month, Day, Year)

MAR 2 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRIPURTO ENI, RASTORALARTO, MI

RE

		•	State of Maryland / Department of Health and N  State Certificate of Death		iene	09653
	4	S	Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
	Physicia		Shelby A. DuPree	March	9, 2006	5:45P M
ý	/Medic	-	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
	- ZAGIIIII		Prince Georges Hospital Center Cheverly		Prince G	eorges
74	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	Year) 9. Birth	nplace (State or Foreign untry)
1	Director		244-80-2867 1 M 2X 57 Yrs. 57 Yrs.	Aug. 2	,1948 Nor	thCarolina
	و ي		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	anyla sho	ž				1 ☐ Yes 2 🔀 No
	he N 28e-1	ect	MD Prince Georges Upper Marlboro  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	untry?
	with a or	늅	540 Harry S. Truman Drive 20774	'	USA	
	within 72 hours atter death with the Maryland ene. than "naturel", or iteme 28a or 28e-f show ha Medical Examiner must be inclified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14 Race - Ame	ncan Indian,
	ter dea	F	Armed Forces?	Rican, etc.)	Black, White	
99	urs a	by	Never Married 2 Married 1 Sec. Give 1 Yes 2 No Specify:  3 Widowed 4 Divorced Year or Dates:		Specify: Bl	ack
ŏ	2 hor	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	ina	16b. Kind of Business/	ndustry
2	Bi."r	jpie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	"'9		
2	filed withi Hygiene. other than	Con	2 Dietary Aide		Hospital	
nd	be filed within 72 hours after that Hygiene. Id other than "naturel", or the wealth that he hearth that he	3e	17. Father's Name (First, Middle, Last)  18. Mother's Nam		Maiden Sumame)	
<u>yla</u>	Ment Ment arke	2	Ernest R. DuPree, Sr. Ora War			
Maryland 21215-0036	es 1 and 2 should be fi of Health and Mental H f Item 27 is merked ot r other traumatic eve		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Patricia DuPree-Lacy/Sister540 Harry S.TrumanD			
	and lealth m 27 her to				20c. Location - City or	
Baltimore,	permit. Pages 1 and Department of Heal Important: If Item 2 eny injury or other once.		Cemetery, crematory or other place)			
Ē	rmen tant:				Wilson, N	
3a	permit. Depentr Imports eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Green 814 Franklin Str			
	20 = 0		100010000000000000000000000000000000000			Approximate
<b>₹</b> )		š.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		est,	Interval Between Onset and Death
j 20	Physician	1	Immediate Cause (Final disease or condition resulting in death)  a. FATAL CARDIAC ARRHYTHMI.	<u>ل</u>		
	/Medical Examiner		Due to (or as a consequence of):			
		7	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury			
	xecul and	xar	that initiated events c			
8760,	cate be executed physician and the burial-transit	dical E				
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Вох	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		23d. Date of del	ivery
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000	s been si	Completed		24a. Was a	n 24b. Were au	topsy findings available completion of cause of
Be	The la te ha age	E		autops perform	med?   death?	2 No
ta	an: tifice tor, p	8	25. Was case referred to medical 26. Place of Deal	th (Check only or		
≥	ysici is cer direc	To B	examiner?  1 Yes 2 No	ome 5 Reside	ence 6 Other (Spe	cify)
0	19 Ph ter th neral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	28d. Describe he	ow injury occurred	
<u>ö</u>	Attending Physician: or death. ector: After this certification by the funeral director,	atic	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records,	r Attu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Town	treet and Number or Ri n, State)	ural Route Number,
Ω	ital o					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier  (Check only one)  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of coatrier 29c. License number	2	29d. Date signed (Mont	h, Day, Year)
	F 3 F 8				_	
	117		30. Name and aedress of person who completed cause of death (Item 23a) (Type, Print)		J-117	
	Je go		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR GARY LITTLE 3001 HoSPITAL DRIVE	CHEVERLY	( M) 20	185
	Sta	ite	31. Date filed (Month, Day, Year)  32. Registrar's Signature		1	
4	Regist		MAR 1 4 2006 Report & Spart			

			1 - For State Registrar	State of Mar		rtificate of	Death	R	leg. No.	5 6	9654	}
	Physici		Decedent's Name (First, Middle, La Inez Mary	st)	Davis			2. Date of Dea Month farch	Day 12, 20	Year 006	3. Time of Dea	ath $\mathbf{P}^M$
	/Medic Examin		4a. Facility Name (If not institution, given 967 Dogwood Tree 5. Social Security Number 6. S	Drive	'In yrs. last birthday	Annapoli If Under 1 Year	r Location of Death	8. Date of Birth (Month, Day	4c. Count	dy of Death Arund		
!	Director		214-48-8341  Usual Residence of Decedent  10a. State 10b. County	1□ M 21XF 91	Yrs.	Months Days	Hours Min.	10/20/	1914	N.Umb	erland Od. Inside City Li	Cŏʻ
	the Mary 28e-f sh	ector	MD Anne Aru	inde1	Annapo	lis 10f. Zip Code		1	10g. Citizen of	What Coun	1 <b>X</b> Yes 2 □	] No
	s 23a or	ral Di	967 Dogwood Tree			21401	Colored (Con	1	United		s	
9000	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Exam nor must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	Rican, etc.)	Speci	ack, White, o	etc.	
Maryland 21215-0036	d within 72 t giene. er then "netu	complete	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired memaker	ation during most of workin d)	9	Domes		lustry	
/land	uld be tile Vental Hy rrked othe	To Be (	17. Father's Name (First, Middle, Last Clarence Fallin	)			18. Mother's Name Gertrude			ame)		
	and 2 sho salth and P n 27 is ma er treums		19a Informant's Name/Relationship (Tim Davis (grand		967	Dogwood T		Route Number			Code)	
Baltimore,	Pages 1: tment of He tent: If iten jury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	Fort Lin		tery 3/16/	2006 1		ood, M	D	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Hos	-4-	3	401 Blade:	<sup>ss of Facility</sup> Fort nsburg Roa	d Bre	entwood			
68760,	Physician and interest that the death certificate be executed to the attending physician and beneathed for use as the burial-transit	Aedical Examiner	23a. Part1. Enter the discusse, or complete shock, or heart latitire. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Coronary Due to (or as a decorporate to the coronary Due to (or as a decorporate to the coronary) Due to (or as a decorporate to the coronary)	Artery I						Interval Betwee Onset and Deal	
P.O. Box		ysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _				ate of delive	ny Day Year	
Records, P.	w requires that the death cer been signed by the attendin should be detached for use	Completed by Physician/A	Part II. Other significant conditions Hypothyroidism	_	not resulting in the		en in Part I.		bacco use col		e cause of death	
al Rec	The law ate has b page 2 st	Comple	Depression Breast cancer					24a. Was a autop: perfor		prior to cor death?	psy findings avai npletion of cause 2 No	lable of
Division of Vital	of or Attending Physicien: Thater death. I Director: Aller this certificated in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1   Yes   2   X   No  27. Manner of Death   X   X   Yes   Yes     2   Accident   Accident   Accident     3   Suicide   6   Could not to determined	09 Place of Injur	Year) 28b. Time Injury	of 28c. Injur Wor M 1	k? Yes 2 □ No	ne 5□ Resid 8d. Describe h	ence 6 1000 ow injury occu	ırred	r) I Route Number,	
	To the Hospitel or Attend within 24 hours atter death To the Funerel Director: completely tilled in by the	edical	(Checklowy 2 Medical Exa	hysician: To the best of miner: On the basis of e and manner state	xamination and/or	nvestigation, in my o	ppinion, death occurre	ed at the time, o	date and place	, and due to	the cause(s)	
	To to com	Z	29b. Signature and the of certifier  30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	29c. Licens D 005		2	3/13/		∪ay, Year)	
1	(5) Sta	ite	Nadia Akhmed, M. 31. Date liled (Month, Day, Year)	D. Registrar		idgley Ave	Annapo	lis, MD	21461			
	Regist	ar	MAR 1 4 200	6 plane	A 199							

	Registrar					partment of F Prtificate of			Reg. No.	6 (	9655
ysician	1. Decedent's Nar	me (First, Middl	le, Last)					2. Date of De		Year	3. Time of Death
Medical	Ruth S	arah Dr						MÄRCH		006	2:35P.M
aminer			on, give street and orial Ho			4b. City, Town, o	r Location of De onsboro	eath	4c. County		ngton
eral	5. Social Security		6. Sex		In yrs. last birthda	) If Under 1 Year	If Under 24 H		th		nlace (State or Foreigntry)
ctor	220-30-7	582	1 □ M 2 🔀	F	95 Yrs.	Months Days	Hours M	in. (Month, Da			vland
Control Control	Usual Residence				0c. City, Town or	Location					0d. Inside City Limit
ad a		10b. County	, shington			Boonsboro				'	1 ŽYes 2 ☐ N
be nutified Director	10e. Street and N		siring con	·		10f. Zip Code			10g. Citizen of V	Vhat Cour	
10		Main S	3+.				21713			U.S.	•
event, the Modical Examinational beneatitied at Be Completed by Funeral Director	11. Marital Status		12. Was	Decedent Eve ed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba		(Specify Yes or No	- 14. Rac	e - Americ	an Indian,
Fu Fu	1 🗆 Never Ma	rried 2 Mar	rried 1 🗀 \	Yes 21 No s, Give		1 ☐ Yes 2 ₹ No	Specify:	ieito nicari, etc.)	Specify	k, White,	White
d by		4 Divorced	d Year	or Dates:							
rt, fre Madical I	(Spe	15. Deceder ecify only highe	nt's Education est grade comple	eted)	(Gir	edent's Usual Occup re kind of work done DO NOT use retired	during most of t	working	16b. Kind of Bu	isiness/Ind	dustry
M dimo	Elementary/Sec	condary (0-12)	Colle	ege (1-4or 5+)	, , ,		naker			Н	ome
matic event, the	17. Father's Name	e (First, Middle,	, Last)				18. Mother's N	Name (First, Middle,	Maiden Sumam	18)	
		Tames E.	. Hesson	ıg			Sac	die E. Br	andenbur	g	
2	19a, Informant's	Name/Relations	ship (Type, Print,	')		iling Address (Street					-
ther tre	Edward I	-	ong (Nep			2 Williams	sport P				
or oth	20a. Method of D		3 □Removal f	from State	Garfield	position (Name of ematory or other place UNICE	<sup>ce)</sup> Ma	rch 26,	20c. Location -		
dinty		5 Other (S		1	Methodis	t_Church_	cem. 20	06		ield	•
eny injury or other to	21. Signature of I	-uneral Service		vis 1	No1414 3	22. Name and Addre	Funera	1 Home Sm	525 Brac ithsburg		
cian lical	23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death	eart failure. List e (Final tion	r complications t t only one cause	that caused the on each line.	e death. Do not e	nter the mode of dyir		diac or respiratory as	rrest,		Approximate Interval Between Onset and Death 3-23-66
iner	Sequentially list of	conditions,	b	ie to (pras a c	consequence of):	V					
he burial-transit		its	<b>1</b>		consequence of):						
or use as the bur		ent pregnant 2 months?	c		consequence of):  pregnancy  Fetal death 3	□Ectopic pregnanc;	,		23d. Dat Moi	e of delive	ery Day Year
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DHMH 17 Rev 1/2001

ORIGINAL

					epartment of Health and Me	•	•	
			1 - For State Registrar		Certificate of Death		2006	09656
			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
	Physici /Medio		LIDA DIA	DANIELS		Month 8,	Day Year 2 <i>006</i>	4:17 A M
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	., .,	4c. County of Death	17017 A
			WASHINGTON ADVENT		TAKOMA PARK		MONTGOMER	y
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign htry)
			228-40-8222 Usual Residence of Decedent	//		08-24-3	4 WASH	INGTON, DC
	irylan ihow	_	10a. State 10b. County	10c. City, Town o	or Location		1	0d. Inside City Limits
	80-f	Director	MD PRINCE GE	EORGE TEMPLI	E HILLS			1XXYes 2 □ No
	with the	급	10e. Street and Number	UESU:F #31 FS	10f. Zip Code	10	g. Citizen of Whal Cour	ntry?
	be filed within 72 hours efter deeth with the Maryland ital Hygiene. Ad other then "naturel; or items 23a or 28e-f show other, the Medical Examinar must be notified at	Funerai	3107 GOOD HOPE AL		2 0 7 4 8	cify Yes or No-	U. S. A.	ean Indian
ထ	or iter		1 ☐ Never Married 2 ☐ Married	1 □Yes 2 K□No	<ol> <li>Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F</li> </ol>	Rican, etc.)	Black, White,	etc.
ğ	rei', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X☐ No Specify:		Specify: BL	ACK
<u>.</u>	"natu	Completed	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation Give kind of work done during most of workin	19	6b. Kind of Business/In	
21215-0036	withir Bne. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+) 4 + YRS.	fe. DO NOT use retired) PARALEGAL		NEW YORK C1 AUTHOR1TY	TY HOUSING
0	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)	77.3.	18. Mother's Name			
lan	should be nd Mental marked c	To B	EDWARD W. DA	ANIELS	LIDA E.	FRIENT	9	
Maryland	2 6 5 5	3	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. M	Mailing Address (Street and Number or Rural	Route Number,	City or Town, State, Zip	Code)
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		LEILA HAIDER - 1		PROSPECT AVE. STANTO			
or E	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1     Burial 2 □ Cremation 3 □ Re	emoval from State	crematory or other place)		0c. Location - City or To	
Baltimore,	permit. Pages Department of I Important: If it any Injury or o	Į., W	4 Donation 5 Other (Specify)		Y MEMO. PARK 3-18- 22. Name and Address of Facility PIN		ANDOVER, MD	FOLL HOUR
Ba	Deperment of the population of		21. Signature of Funeral Service License	560 6	524 - 8TH STREET, N			
			23a. Part1. Enter the disease, or complic	cations that caused the death. Po not	enter the mode of dying, such as cardiac or			Approximate
,	Physician		Immediate Cause (Final					Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	MASSIVE ACUTE N  Due to (or as a consequence of):				
	Examiner		Sequential list conditions. b.					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		_		
	be executed sicien and burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
09/	a 5 0	cal	d					
9		-						
Box	requires that the death certifica seen signed by the ettending ph hould be deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 ☐Ectopic pregnancy		23d. Date of delive	,
0	at the dea by the et teched fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 Other (specify)		Month	Day Year
J.	that the ed by detection	Ph	Part II. Other significant conditions cont	tributing to death but not resulting in th	ne underlying cause gwen in Part I	23a Did tob	acco use contribute to the	o cause of death?
Vital Records,	urres sign Id be	d b	•		and onlying datase great in a lart.	1 🗆 Yes		ably 4 □Unknown
Ö		Completed				24a. Was an		
Ä	The law sete has b page 2 sl	E O				autopsy	prior to cor ed? death?	psy findings available apletion of cause of
Ital	Ψ	0	25. Was case referred to medical	3.0 - 01-2-	26. Place of Death		ZNo 1□Yes	2□ No
01 <	\$ w 0	To B	examiner? 1 Tes 2 No	ospital: 1 / Inpatient 2   ER/Outpa	Othor		nce 6 □Other (Specif)	1)
			27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim. Injury	e of 28c. Injury at 21		v injury occurred	<u> </u>
Sic	Attending F r death. actor: After by the funer.	Icat	2 Accident investigation 3 Suicide 6 Could not be	CRo. Disco of lainer. As house (c	M 1 Yes 2 No			
5	in the second	Certification:	4 ☐ Homicide determined	28e. Ptace of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	Bf. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	Hospital or 24 hours afte Funeral Difeely filled in		29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, d	leath occurred at the time, date and place, ar	nd due to the car	use(s) and manner as st	ated
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examinations)	ar: On the basis of examination and/o and manner stated	or investigation, in my opinion, death occurred	d at the time, da	te and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	lilami	29c. License number	29	d. Date signed (Month,	Day, Year)
^	( 5		) myw c	and 7	53733		MARCH 14,	2006
K	115/		30. Name an person who con SANJIV LAILHANPAL,	mpleted cause of death (Item 23a) (Ty)		WD 0070	E	
	Sta	te.	31. Date filed (Month, Day, Year)	A Registrar's Signature	TAL DRIVE CHEVERLY,	MV 20/8	ס ס	es es es Allaires
	Registr		MAR 1 5 2006	Red W A	met o			

			1 - For State Registrar		f Marylar			nt of H				Reg. No.	006	09657
3	Physici	an	Decedent's Name (First, Middle							2	. Date of Dea Month	ath Day	Year	3. Time of Death
10.486	/Medic	al⊲		n Dunn-Smi			1				March	6	2006	9:10 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution				4b. Cit		Location of			4c.	County of Death	
	Function	- T	Holy Cross I  5. Social Security Number		7. Age (In yrs.		If Unc	Bur ler 1 Year	tonsv:		. Date of Birt	h		gomery  place (State or Foreign
- 1 to 1	Funeral Director		579-74-5764 Usual Residence of Decedent	1 □ M 2 🛣 F	4	V	Month	s Days	Hours	Min.	(Month, Da)	y, Year) 195	Col	sh., DC
	yland how		10a. State 10b. County		10c. C	ity, Town or Li	ocation							10d. Inside City Limits
	B Mar	ctor	Maryland Princ	ce George'	s			Hva	attsvi	11e				1 <b>X</b> Yes 2 □ No
	ith th or 28	Directo	10e. Street and Number	0			10f. 2	ip Code				10g. Citiz	zen of What Cou	intry?
	ath w		6037 - 10t						2078				United	
	itemi	Funeral	11. Marital Status  1 □ Never Married 2 X Marr	Armed Fo		J.S. 13.	Was Dec	edent of Hi ecity Cubai	spanic Origi n, Mexican,	in? (Speci Puerto Ric	fy Yes or No- can, etc.)	-   1	<ol> <li>Race - Amer Black, White</li> </ol>	, etc.
32	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes Giv	0		1 🗆 Yes	2XNo	Specify:				Specify:	rican
Š	2 hou		15. Decedent			16a. Dece	dent's Us	sual Occupa	ition			16b. Kir	AII and of Business/l	nerican ndustry
212	thin 7	pie	(Specify only highes Elementary/Secondary (0-12)	Colfege (1	-4or 5+)	(Give	kind of v DO NOT	vork done d use retired,	uring most o	of working				
7	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show the than hadical Examiner must be notified at	Completed	12th			Comp	uter	Oper	ations					nment
	d tal	Be	17. Father's Name (First, Middle,	ŕ					18. Mother	's Name (I	First, Middle,	Maiden	Sumame)	
<u> </u>	2 should be and Mental is marked c	2	Ernest			1							Watts	
Maryland 21215-0036	permit. Pages 1 and 2 should Depertment of Health and Men Important: If item 27 is marke any injury or other traumatic one.		19a. Informant's Name/Relations  Lawrence C.		and		-				Route Numbe sville	-	Town, State, Z.	,
ē,	1 and Health tem 27 other tr		20a. Method of Disposition	-	20b.	Place of Dispo	sition /N	ame of		Dat			cation - City or 1	
Baltimore,	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	emetery, cre • Linc			· 1	2/11/	2006			
	permit. Pag Depertment Important: I any injury c		21. Signature of Funeral Service		11				s of Facility				entwood ral Hom	
ñ	Page 1		The A	Hent.	=		40	01 Be	nning				., DC 2	
140			23a. Part. Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the dea	th. Do not en	ter the m	ode of dying	, such as c	ardiac or r	espiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		astati	c Brea	st C	ancer						Onset and Death 2½ Years
17	/Medical Examiner		resulting in death)	Due to (	or as a conse	quence of);			,					
AE:		7.0	Sequentially fist conditions,	b	or as a conse	Tuesce of								
	ned 1 Insit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>(</b>	01 43 4 0011301	quoriça or <sub>j</sub> .								
oʻ	exect an and rial-tra	Exa	that initiated events resulting in death) Last	C. Due to (	or as a conse	quence of):								
8/60	cate be executed obysician and the burial-transit	dicai		d										
<u> </u>	entifica ing ph e as t		fF FEMALE:					<u></u>						
Rox	death certific e attending p id for use as i	ian/	23b. Was decedent pregnant in the past 12 months?		irth 2 Fet	af death 3[		pregnancy				2	3d. Date of deli-	very Day Year
	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□ Unkno	ant at time of own	death 5t	Other (	specify)						-,
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ecords,	w requires been sign should be	ed by									101	/es 2[	XNo 3 □ Pro	bably 4 Unknown
ပ္တ	law reas bee	piet									24a. Was		24b. Were aut	opsy findings available
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<u>ta</u>	hysician: Th nis certificate I director, pag	Be	25. Was case referred to medical examiner?						26. Place o	of Death (6	Check only o			
>	hysic his ce	To	1 ☐ Yes 2 💢 No			ER/Outpatie	nt 3 🗆 [	OOA Othe	IT. 4 □ Nurs	sing Home	5 ☐ Resid	dence 6	Other (Spec	Rehab. Ctr.
Ĕ	ding Phy h. Alter this funeral c	on:	27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o		28c. fnjury Work			d. Describe h	now injury	occurred	
<u>s</u>	ten deat tor: the	icat	2 Accident Investig	not be	of Injury - At h		M		res 2 □ N		f Location /	244	d Alicenter O	
Division of Vital R	after deat Director:	Certification:	4  Homicide determ	buildir	ng, etc. (Spec	ify)	reet, lact	ory, onice		201	City or Tox	vn, State)	i variosi oi Au	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edicai C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba	asis of examin	owledge, deat ation and/or ir	h occurre	d at the tim on, in my op	e, date and inion, death	place, and	d due to the a	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Ho within 24 I To the Fu completely	Mec	29b. Signature and little of certifie		ner stated.		2	9c. License	number			29d. Date	e signed (Month	, Day, Year)
	r s r ō		1 Kom	than -	- 11	<b>C</b> 5	Andrew Co.	Т	53829	)			arch 10	
D	16		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type,	Print)		,,,,,,,,,			14	arcii 10	, 2000
1			Kevin Shar	nnon, M.D.	7525	Greenwa		enter	Dr.,	Ste.	205,	Gree	nbelt,	MD 20770
	Sta Registr		31. Date fifed (Month, Day, Year) MAR 1 5 200	32. R	egistrar's Sign	afure	2							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 11, 2006 9:30 P. Amelia Schmidt Dees March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 21X F Yrs. Director 91 March 5, 1915 Washington, DC 215-50-6954 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Director Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 United States e filed within 72 hours after death with Hygiene.
other than "natural", or Iteme 23s 388 Russell Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify ģ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Homemaker or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Schmidt ဂ္ Charles Α. Louise M. Kraft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32714 19a. Informant's Name/Relationship (Type, Print) 109 Spring Chase Circle, Altamonte Springs, FL Karen D. Shannon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 3/22/2006 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final respirator **Physician** Insuk day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 40 oventilation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit law requires that the death certificate be executed multiple that initiated events Don resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No After this certification, I or Attending Physician: 25. Was ase referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28a. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 1 Natural 5 Pending tall in home 1 Yes 24 hours after death.

Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Gaithershore 409 To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg Ave olinst. teven ILUSSOI 31. Date filed (Month, Pay Year) 32. Registrar's Signature State 2006 Registrar

		1	For State Registrar	State of	f Marylan		rtment of H		Mental Hygid	ene 2006	09659		
			Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Yea	3. Time of Death		
	Physicia		MORRIS		DANLEY				MARCH 9, 2		8:20 A M		
	/Medic Examin		4a. Facility Name (If not institution, MANOR CARE OF SILVI		mber)		4b. City, Town, or SILVER S	Location of Death	1	4c. County of De			
	Funeral Director		5. Social Security Number 431-24-9446	3. Sex 1 AM 2 ☐ F	7. Age (In yrs. I 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) FEBRUARY 2	(ear) 1922 Al	Birthplace (State or Foreign Country) RKANSAS		
	D		Usual Residence of Decedent		100 6	. Town or lo	ention				10d. Inside City Limits		
	show	_	10a. State 10b. County	- The state of the		y, <b>Town</b> or Lo	Cation				1 ☐ Yes 2 🖄 No		
	89-f	ecto	MARYLAND MONTGO	MERY	RUC	CKVILLE	10f. Zip Code		100	g. Citizen of What	Country?		
	with the	E C	10e. Street and Number	TVE			20853		101	USA			
	death with the Maryland rms 23e or 28e-f show rmust be notified at	Funeral Director	12803 PARKLAND DR	12. Was Dece	edent Ever in U.	.S. 13. \	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - A	mencan Indian,		
^	fter d	표	1 ☐ Never Married 2 ☐ Marrie	d 1 ☐ Yes	2 No		fYes, specify Cuba 1 ☐ Yes 2 🔼 No	an, Mexican, Puen	o Hican, etc.)	Black, W			
2	el', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or D	/8	I	1 Yes 2 No	Specify:		Specify:	WHITE		
215-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup	durina most of wo		6b. Kind of Busine	ss/Industry		
2	ne	mpi	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retired	,	DEDUTCOD	PRIVATE			
7	iled w Hygier ther t	ပိ	17. Father's Name (First, Middle, L	ast)		SHIPP	ING AND REC		ne (First, Middle, M.				
and	d be f	o Be	BERT L. DANLEY	,				JESS <b>I</b> E	BLAIR				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. Inportent: If item 27 is marked other than "naturelt, or items 23e or 28e-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	Ĕ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Number or Ri	ural Route Number,	City or Town, State	e, Zip Code)		
Σ	nd 2		WAYNE DANLEY - S	ON		3105	BEETHOVEN V	VAY; SILVEF	R SPRING MD	20904			
Baltimore,	item item		20a. Method of Disposition	2 Demondiform		Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date 2	0c. Location - City	or Town, State		
Ë	Page Int. If		1 □XBurial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		PA		EMORIAL GAR	1		ROCKVILLE,			
a	rmit. spartn sporte ly inju		21. Signature of Funeral Service L	icensee	1	2:	2. Name and Addre	ss of Facility HI	NES-RINALDI	FUNERAL H	OME		
m —	89 = 29			T. Klor					E; SILVER S				
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that only one cause on e	caused the deat each line.	h. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death		
- 14	Physician		Immediate Cause (Final disease or condition	a SEPS	SIS						DAYS		
	/Medical Examiner		resulting in death)		(or as a consec	uence of):					YEARS		
	LXdiiiiici	_	Sequentially list conditions,	D	b. ARRYTHMIA  Due to (or as a consequence of):								
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 20 0.00.00	,,-							
	axecu al-tra	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):							
760,	sate be executed obly sician and the burial-transit	dicail		d									
89	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medi	IE SEAMLE										
Вох	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna birth 2 - Feta	aldeath 3[	⊒Ectopic pregnanc	у		23d. Date of Month	delivery Day Year		
Ш	e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of o nown	death 5[	Other (specify)						
<u>о</u> .	that the de ned by the a detached f	Phy	Part II. Other significant condition	ns contributing to o	death but not res	sulting in the u	underfying cause gr	ven in Part I.	23e. Did tob	acco use contribut	e to the cause of death?		
ds,	ires tha signed d be del	d by	DIABETES ME				, ,		1 □ Ye	s 2□No 3[x	Probably 4 Unknown		
Ö	v require been si should l	Completed							24a. Was ar	24b. Wer	autopsy findings available		
Rec	has ge 2 :	Id III	CORONARY AR	TERY DISEAS	SE				autopsy	ned? deat	to completion of cause of h? Yes 2□ No		
Vital Record		e Co	25. Was case referred to medical					26 Place of De	1 ☐ Yes 2 eath Check onlone		Tes ZII NO		
	Physicien: r this certifica ral director, I	To Be	examiner?  1 Yes 2 No	Hospital:	Inpatient 2	] ER/Outpatie	ent 3 DOA	hoe	Home 5 ☐ Reside		Specify)		
o	g Phy er this eral c		27. Manner of Death	28a. Date		28b. Time (		ry at	28d. Describe ho	w injury occurred			
0	Attending In death.  ector: After by the funer	atio	1 Natural 5 Pendin 2 Accident investig	pation	,,	]		Yes 2 □ No					
Division	I or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could reducterm	200. Flac	e of Injury - At h	nome, farm, s ify)	treet, factory, office		28f. Location (Sti City or Town		r Rural Route Number,		
0	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer					- 4 4 4	the constant of the constant o	: data and sta	and due to the	uleo(s) and mann	ar as stated		
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier Certifyin (Check only 2 Medical	Examiner: On the	le best of my kn basis of examin nner stated.	owledge, dea ation and/or i	ith occurred at the t nvestigation, in my	opinion, death occ	ce, and due to the ca curred at the time, da	ate and place, and	due to the cause(s)		
	thin 2 of the omple	Mec	29b. Signature and title of certifie		) a		29c. Licen	se number	25	9d. Date signed (A	fonth, Day, Year)		
	con con		· Kai	1 Ch Ch	1 to	~ O 1.	D19	609		3/11/2006			
	4		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type	o, Print)			2,22,2000			
			RAMAN R. TIII.T M.I	10810 D	ARNESTOWN	ROAD SI	HTTE 202: G	AITHERSBUR	G MD 20878				
		ate	31. Date filed (Month, Day, Year)	1 4 2006	Registrar's Sign	nature	poule						
	Regist	trar	MAR	1 4 2000		0 1	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 745 4a. Facility Name (Hobt institution, give street and number) Dalton 03 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Salisbury Mb.

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Hospice Der 16. Sex Wicomico pasta 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□F Yrs. 293-14-2030 Nov.23,1925 80 Kentucky Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exemina-10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes XX No Be Completed by Funeral Director Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Fairhaven Court 21811 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Dalton Geneva Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Fairhaven Court, Ocean Pines, Md. 21811 Marlene Dalton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3-15-2006 Frankford, DE 4 Donation 5 Other (Specify) 21. Sun don of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 23a Part 1. Entertible disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithire. Sier only one cause on each line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funerst Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 🗀 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 25 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [ ] Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D26278 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) BOX 1733 Salish E. Couply MS Constal Hospie 31. Date filed (Month, Day, Year) 32. Signature State MAR 1 5 2006

Registrar

			1 - For State Registrar	State of Maryla				lealth a Death			eg. No.	16	0966	)
4-5	Physici	an	1. Decedent's Name (First, Middle, La Ella Grim Davi						,	2. Date of Dea Month March	Day 12	Year	3. Time of	Death P M
	/Medic Examir		4a. Facility Name (If not institution, given Anne Arundel Me			4b. City		r Location of Annap	of Death	March		2006 Inty of Death Anne	2:40 Arundel	
	Funeral Director		5. Social Security Number 6. S 111-16-8068	Sex 7. Age (In yr. 1 ☐ M 2XX¥ 79	s. last birthday, Yrs.	Months	Days	If Under : Hours	Min.	8. Date of Birth (Month, Day NOV 22	Year)		nplace (State o untry) unsylvar	
	Maryland	tor	10a. State 10b. County Maryland Anne Ar	i	City, Town or L	ocation	A	nnapo	lis				10d. Inside Ci	-
	th with the 23a or 28s	al Director	10e. Street and Number 1718 Long Green	Drive		10f. Z	p Code	21409		1		of What Con	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction of the multiple at Ance.	by Funeral	11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Dec If Yes, sp		lispanic Origan, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	E	Race - Amer Black, White ecify: W		
Maryland 21215-0036	within 72 ho ene. than "natur he muses!	Completed by	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	16a. Dece (Give life.	DO NOT	ork done	during mosi 1)	t of workir	ng		f Business/i		
land 2	uld be filed fental Hyg rked other lic event,	To Be C	17. Father's Name (First, Middle, Last John L. Grim	)				18. Mothe		(First, Middle, A. O Br	Maiden Sun			
, Mary	and 2 shou alth and M 27 is man er traumai		19a. Informant's Name/Relationship Chester Davis/	Type, Print) husband		-				Route Number Annap	-		ip Code) 21409	
Baltimore,	Pages 1 and of He not of He int: If item		20a. Method of Disposition  1  Burial	Removal from State	Place of Displacementary, cre Linc	matory or	other plac			ate 4/2006		on - City or 1 ntwood	rown, State , Mary]	land
Balti	permit. Departn Imports any Inji		21. Sign tu Funeral Strvice Lice	- Tille						nn M. Ta ter St.,				
	Physician and Medical Examiner and physician and physician and the prifar transit	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Souther translate condition: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	tute equence of):  you uence of):					r respiratory arr			Approximate Interval Beh Onset and I	ween
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Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	H	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injur Wor	7 (110	2	ne 5 Reside			cify)	
Divis	tal or Attend rs after death al Director: /	Certification:	3 Suicide 6 Could not be determined		home, farm, st	reet, facto	ry, office		2	28f. Location (S. City or Town	treet and Nu n, State)	umber or Ru	ral Route Num	ber,
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	Vith Com	Σ	29b. Signature and title of certifier	Hann	MD			e number	306				i, Day, Year)	
			30. Name and address of person with	completed cause of death (It	em 23a) (Type	Print)	tga 7	le R	1	Ste 30	o lAn	napole	s mo	7140
	Sta Registi		31. Date filed (Month, Day, Year)	Registrar's Sig	nature							/		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician 1.0° 2006 Dale S. Dudlev 7:03 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Baltimore Towson 8. Date of Birth (Month, Day, Year) Oct 4, 1939 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**½**F Illinois Director 360 32 3078 66 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Woodbine Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14875 Union Chapel Rd. 21797 United States or iteme 23a death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. ☐Yes 2 🔼 No f Yes. Give 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within f Heelth and Mentel Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Retail Area Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond J. Shilvock Ruth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 sh Department of Heelth and Important: If Item 27 Is n any injury or other traun once. James B. Dudley/Husband 14875 Union Chapel Rd Woodbine, MD 21797 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 3-11-2006 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 olln 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death MENINGEAL CARCINOMATOSIS **Physician** reak /Medical Examiner METASTATIC Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the detached ete hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificete 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 | Inpatient examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE Certification; To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25643 2006 (Item 23a) (Type, Print) endale treet 6701 N Charles 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State **MAR 13** Registrar 2006

DHMH 17 Rev 1/2001

DAK

			State of Maryland / Depa 1- State Amend Items 29d per Dr., G853.	riment of Health and M 13/29/06dhb tificate of Death	lental Hygien	906	09663
₹.	Dhysiair	20	Decedent's Name (First, Middle, Last)			ay Year	3. Time of Death
	Physicia /Medic		Darlene Ann Doody		March 14,	2006	7:37 A M
32:	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death	1
		AL.	Frederick Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Frederick  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	rederick	Inland (State or Foreign
В	Funeral Director		238–76–6590 1 M 2 M F 59 Yrs.	Months Days Hours Min.	(Month, Day, Yea	1946 Nort	place (State or Foreign intry) th Carolina
14.			Usuat Residence of Decedent		NOV. 19,	1940  NOL	u Carolina
	nylan how		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
	Ba-1 e	Director	Maryland Frederick Thurmont				1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	intry?
	be filed within 72 hours after death with the Maryland ital Hygiene. Indother then "naturel", or Iteme 23a or 28a-1 show event, the Medical Examinational banding at	E	7186 Browns Lane	21788	USA	14 Days Asset	
	item item	Funeral	Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
36	irs aft	by F	1 □ Never Married 2 🔯 Married 1 □ Yes 2 📆 No If Yes, Give 1 3 □ Widowed 4 □ Divorced Year or Dates:	☐ Yes 2M No Specify:		Specify:	<b>4.</b> –
21215-0036	2 hou		15. Decedent's Education 16a. Deced	ent's Usual Occupation	16b.	Whi Kind of Business/l	
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2	e filed within al Hygiene. I other then vent, Ite Ma	Con		Writer		vernment	
nd	be filed tal Hygir d other	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Sumame)	£
yla	should be and Mental marked c	ဥ	Edward Davis	Ruth Davi			
Maryland	2 8 8 8			g Address (Street and Number or Rura			
	es 1 and of Health fitem 27 r other tr		Nathan L. Doody, husband 7186 I	Browns Lane, #34,		Maryland Location - City or 1	
Baltimore,	in it of 1		1 N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crem	natory or other place)			
뜶	ortani njury			t Cemetery 3/18/		derick,	
Ba	permit. Pages. Department of I Important: If ite eny injury or of once.			Name and Address of Facility Kee Of East Church Str			
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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Box	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Catania araanaan		23d. Date of deli-	very
	death e atte	icia	1 Ves 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
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	law requires that as been signed b 2 should be deta	by F	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.			the cause of death?
ecords,	w require been si should i		<u>SSLD</u>		1 🗌 Yes	2 No 3 Pro	bably 4 DUnknown
ecc	law r as be	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
E	The ate h	Con			performed? 1 ☐ Yes 2 🔀 N	death?	2 🗌 No
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of	hya this	T0	1 Yes 2 No Hospital: Impatient 2 ER/Outpatien		me 5 Residence		eify)
nc		lon	27. Manner of Death  1 ☐ Matural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?  M 1 Tyes 2 No	28d. Describe how in	jury occurred	
isic	Attending in death.	icat	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre		28f. Location (Street	and Number or Ru	ral Route Number
Division	2 2 2 2	Certification:	4 Homicide determined building, etc. (Specify)	sor, radiory, office	City or Town, Sta		
_	To the Hospital of within 24 hours at To the Funeral D completely filled it	edicai C	29a. Certifier (Check only 2   Medical Exeminer: On the basis of examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as	stated. to the cause(s)
	To the h within 24 To the F	Medi	one) and manner stated.	29c. License number		Date signed (Month	i, Day, Year)
			> Jeles Verma M.D	D-57796	J	March 1	47 4000
	1		30. Name and factress of person who completed cause of death (Item 23a) (Type, Lalit M. Verma, MD, 400 West Seventh S		MD 2170	1	
Sec. Sec.	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 9 2006  32. Registrar's Signature	7	21,0		
E.	5	A	METH N O COOL STREET				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Month **Physician** FIK A-M ENNIS E LASKO\_/ MARCH 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 14, 1912 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1**∑**M 2□ F 94 214-18-8979 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is markad other than "natural", or Itams 23a or 28a-f shov traumatic evant. Its Modical Examinations to be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD Prince Georges Aquasco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23402 Neck Rd. 20608 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 

Widowed 4 

□ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Mechanic Mayberry Lumber 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be to nent of Health and Mental I sut; If item 27 Is marked of Joseph H. Ennis Zorra Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Butler/Daughter 21611 Aquasco Rd, Aquasco, Md 20608 If item 20b. Place of Disposition (Name of Christian Table)

Christ United Meth 3/17/06 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Aquasco, Md permit. Page Department o \* 4 ☐ Donation 5 ☐ Other (Specify) Church 21. Signature of Paneral Service Licensee 22. Name and Address of Facility Adams Funeral Home, PA 20605 Aquasco Rd Slas 191 Aquasco, Md. 20608 AQUASCO
e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
List nation of cause on each line. 23a. Part1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Aetrio sclestic /Medical Due to (or as a consequence of): **Examiner** Antivisclenty Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Diractor: After 1 Natural 2 Accident 5 Pending 2 🗆 No investigation 1 TYes filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier 735206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Luigh Rosh Fort when ing the TANNER M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	S	tate of	Maryland		artment of H rtificate of L		nd M	ı	Reg. No.	006	09665
. %	Physicia		1. Decedent's Name (First, Middl	, Last)							<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic	All			klin						March	7	2006 County of Death	5:20P <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution			oer)		4b. City, Town, or				46. 0		George's
			1804 - 6 5. Social Security Number	6. Sex		. Age (In yrs. las	t birthday)	If Under 1 Year	Cheve	4 Hrs.	8. Date of Birt	h .	9. Birth	place (State or Foreign
	Funeral Director		578-22-2761		2□ F	82	Ven	Months Days	Hours	Min.	(Month, Da	v, Year) 0 • 19		th Carolina
	D		Usual Residence of Decedent											10d. Inside City Limits
	arylar show	_	10a. State 10b. County			10c. City,	10Wh or Lo	ocation						1X Yes 2 No
	8a-f	Director		e Ge	orge's			10f. Zip Code	Cheve	er1y		10a Citiz	en of What Cou	inter?
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	eath	Funerai	1804 - 61s			ent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba			cry Yes or No	y	4. Race - Ameri	ican Indian,
0	riter d	Fun	1 ☐ Never Married 21 Mar	ried	Armed Forc 1 X Yes 2 If Yes, Give			If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		, Puerto	Rican, etc.)		Black, White,	, etc. Erican
3	hours after death with the Maryland lural', or Itema 23a or 28a-1 show al Examinat must for molilied at	l by	3 Widowed 4 Divorced		Year or Date	es:		TIL Tes ZIL NO	Specify:				Specify: Ar	merican
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7	within 72 ene. than "nai	mpi	Elementary/Secondary (0-12)		College (1-4	4or 5+)	IIFO.	DO NOT use retired					Corrorer	
7	filed v Hygie other t		17. Father's Name (First, Middle,	Last)	2			Computer			(First, Middle,	Maiden S	Goveri Sumame)	imenc
Z Z	ould be Mental larked o	To Be	Benjam	in Fr	anklin	ı					Sensi	e The	omas	
Maryland 21215-0056	should and Men a marke umatic	-	19a. Informant's Name/Relations				19b. Maili	ing Address (Street a	and Numbe	r or Aura	I Route Numbe	er, City or	Town, State, Zi	ip Code)
Ž	and 2 alth a alth a 27 ls		Florine Fran	klin/	Wife			04 <b>-</b> 61st					20785	
baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show appring to other traumatic avant. The Medical Examinat must be notified at ancie.		20a. Method of Disposition  1 Burial 2 Cremation	3 □Ren	noval from St	20b. Pla	ce of Disp netery, cre	osition (Name of matory or other plac	e)		Date	20c. Loc	cation - City or T	own, State
Ĕ	Pages ment of I ant; If Its ury or o		4 Donation 5 Other (	ipecity)	10421 110111 01	Harm		Memorial 1					ndover,	MD
ğ	Depart Depart Import any inj		21. Signature of Funeral Service	License	- (		2	2. Name and Addres		_				20010
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	Physician /Medical Examiner	Examiner	shock, prheart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. b	Esc Due to (o Gas	phageal	nce of): hage:	cer al Reflux	Disea	ase				Interval Between Onset and Death
. DOX OO LOO,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No	d. 23o	. If yes, outco 1 ☐ Live bir 4 ☐ Pregna	ome of pregnand the 2 Fetal country at time of dear	cy death 3	□Ectopic p <b>reg</b> nancy □ Other (specify) _			01186900	2	3d. Date of deliv	very Day Year
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		Con	Type II	Diab	etes 1	Mellitus	3				perto 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 □ No
Vital	sician: Th certificate rector, pag	Be (	25. Was case referred to medic examiner?		no stale			Oth		_	h (Check only			
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ב		on	27. Manner of Death 1 Natural 5 □ Pend	ng igation	28a. Date of (Month	n, Day Year)	Injury	Wor	k? Yes 2 □	No	Edd. Doddribo	now injur	, 55041104	
DIVISION	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 □ Could		28e. Place o	of Injury - At hon	ne, farm, s	treet, factory, office						ral Route Number,
<u>&gt;</u>	P He	erti	4   Homicide	- 1	buildin	g, etc. (Specity)		•			City or To			
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	To the To the To the To the Second	Me	29b. Signature and title of centif	101				29c. Licens					e signed (Month	*
)	14/			M	77	_			D5555	9			March 9	, 2006
	0		30. Name and address of perso	who com	pleted cause									
-	-46		Thomas E			The second secon		reenway C	enter	Dr.	, #316,	Gre	enbelt,	MD 20770
	St Regist	ate rar	31. Date filed (Month, Day, Yea  MAR 1 4 2006	Ro-	32. Re	egistrar's Signati								

		-	For State Registrar	State of N	Maryland		artment of F		nd Mental Hy	giene Reg. No.	6 09	966	56
	Dhamini		1. Decedent's Name (First, Middle	e, Last)	_				2. Date of De Month	Day	Year	Time of	
	Physicia /Medic		D'Can-	Fitzpatric					03-05-			:08	A M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o		Death		y of Death e George	010	
			Prince George's 5. Social Security Number		Center Age (In yrs. Ia	ast birthday)	Chever 1  If Under 1 Year		4 Hrs. 8. Date of Bir	th	9. Birthplace		or Foreign
П	Funeral Director		430-64-3632	1 <b>X</b> M 2□ F	70	Yrs.	Months Days	Hours	Min. 08-27-	1935	Ethel,		_
	ס		Usual Residence of Decedent								1404.1	Inside Cit	
	show	_	10a. State 10b. County	0 -1-	10c. City	, Town or Lo	tsville					XXYes	1
	Ba-f	ecto	Maryland Prince	George's		пуац	10f. Zip Code			10g Citizon of	What Country?		
	a or 2	Funeral Directo	10e. Street and Number	Avanua			2078	35		rog. Oilizer of	USA		
	leath	eral	2304 Tuemmler	12. Was Decede		S. 13. V			n? (Specify Yes or No Puerto Rican, etc.)	)- 14. Ra	ce - American Ir	ndian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event. The Medical Exercites must be ruitlied at	by Fun	1 Never Married 2 Marr 3X Widowed 4 Divorced	If Yes, Give	No No		f Yes, specify Cubi 1 ☐ Yes 2 <sup>X</sup> No	Specify:	Puerto Rican, etc.)		ack, White, etc.		
21215-0036	2 hou	Completed		t's Education st grade completed)			dent's Usual Occup		of working	16b. Kind of I	Business/Industr	гу	
21.5	within 7 iene. than r	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retire	d)		Fod Co	vernmen	+	
21	e filed within al Hygiene. I othar than vant, the Me		12th	(201)		Nu	rsing As		s Name (First, Middle			. L	
and	hall Hall Had of	Be	17. Father's Name (First, Middle, Barner Fitzpa						rnella Spe				
Maryland	2 should be and Mental Is marked o	우	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street		or Rural Route Numb		n, State, Zip Coo	de)	
Z	and 2 seath ar n 27 is		Donald R. Fitz						,SE Wash.				
re,	s 1 ar f Hea item otha		20a. Method of Disposition		20b. Pl		sition (Name of natory or other pla		Date		- City or Town,	State	
Ë	Page nent o nt: If		1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		Lin	coln M	lem.Cemet	ery 3	/14/2006	Suitlan	d,Maryl		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Service	Licensee	374		Name and Address		c. 4111 Pe	nn.,Ave	. Suit1		746 Md.
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cau	sed the death	n. Do not ent	er the mode of dyi	ng, such as c	ardiac or respiratory a	rrest,	App	proximate erval Bet	e ween
	Physician		Immediate Cause (Final disease or condition				HYTHMIA				On	set and [	Death
	/Medical		resulting in death)		as a consequ		11 110 1111						
Е	Examiner		Sequentially list conditions,	b									_
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or	as a consequ	Jence of):							
	sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):							
8760,	a be e sician buria			d									
9	ificate b g physic as the b	edic											
Box	odeath certificate be executed ne attending physician and ed for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal nt at time of de	death 3	Ectopic pregnanc Other (specify)	у			ate of delivery Ionth Day	y ,	Year
P.0	law requires that the de as been signed by the 2 should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditi	one contributing to deal	th hut not resu	ulting in the u	nderlying cause or	ven in Part I	23e. Did	tobacco use co	ntribute to the ca	ause of c	death?
ds,	signe d be c	d by	ratti. Ottor significant sonati	one commoning to doc		anning an and a	nasny mg saddo g		1 🗆	Yes 2□No	3 🗌 Probably	4 12	Unknown
Vital Records,	w requir been s should	Completed							24a. Was	an 24b	. Were autopsy	findings	available
Rec	9 2	d L			<del>-</del>					psy ormed2	prior to comple death? 1 ☐ Yes 2 ☐	ation of c	ause of
ā	i <b>cian:</b> Th certificate rector, pag	e Co	25. Was case referred to medica	N				26 Place	1 ☐ Yes of Death (Check only	2 No	1 Yes 2	1 NO	
	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inc	patient 2 👺	ER/Outpatie	nt 3 DOA		sing Home 5 Res		ther (Specify)		
1 of	ding Phy I. After thi funeral c	n: T	27. Manner of Death	28a. Date of		28b. Time o	f 28c. Inju			how injury occi			
ior		atlo	E C Troordorit	igation		,,		Yes 2□N					
Division	afor Attano after deatl Diractor: d in by the	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace of	f Injury · At ho g, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location City or To	(Street and Nur iwn, State)	nber or Rural Ro	oute Num	nber,
	To tha Hospital or At within 24 hours after C To tha Funaral Dirac completely filled in by	edical C	29a. Certifier (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred at the ti	ime, date and opinion, deat	place, and due to the h occurred at the time	cause(s) and r , date and place	nanner as stated e, and due to the	d. e cause(s	s)
200	To tha H within 24 To tha Fi complete	Me	29b. Signature and title of certific	Se / 1			29c. Licen	se number		_	ned (Month, Day	, Year)	
¥	· ima	1	I Jonel Si	The M.	/,		D589.	57		03-15-	2006		
7	(5)		/ / /	who completed cause				0	hava-1 M	anvland	20785		
	9		GARY LT.  31. Date filed (Month, Day, Year	TTLE, M.D.	300	1 Hosp	ital Dri	ve C	heverly, M	ar A Tallo	20703		
	Sta Regist	ate rar	MAR 1 5 2	006	gistrar's Signa	Apre	the same						

		1 - For State Registrar	State of N	Maryland / D	epartme <i>Certifica</i>	nt of He	alth and M <i>eath</i>		giene [] [] Reg. No.	6	0966/
Physic	ian	1. Decedent's Name (First, Middle, Las			771			2. Date of De Month	ath 12, 2006	Yeer	3. Time of Death  11:30p M
/Med	ical	Helen 4a. Facility Name (If not institution, give	G.	(r)	Fluhr		ocation of Death	March	4c. County		11:30b
Exam	iner	Carriage Hill Nu				Bethes			Mont	gome	ry
Funera Directo		5. Social Security Number 6. Se		Age (In yrs. last birth	nday) If Und Month		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 7	th iy, Year) 1910	9. Birthpl Count Po	ace (State or Foreign try) cland
pur		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10	Od. Inside City Limits
Aaryla t •ho	5		-0								1 □Yes XX No
the N	Director	Maryland Montgot 10e. Street and Number	mery	Chevy (		Zip Code			10g. Citizen of W	/hat Coun	try?
h with	a D	8802 Altimont Lan	e			2081	L <b>5</b>		US	A	
DESIGNMOFE, IMBLY ISING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Expris activitative notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 1 If Yes, Give Year or Dates	s? <b>건보</b> ㅇ	If Yes, Sp	becity Guban,	oanic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	ыас	- America k, White, e : <b>Asia</b> :	etc.
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Us (Give kind of v	sual Occupati	on ring most of work	king	16b. Kind of Bu	sinøss/Ind	lustry
Mithin Mithin	dm	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Homes				Own H	lome	
Hygie ther the	ပိ	12 17. Father's Name (First, Middle, Last)			пошет		8. Mother's Nam	e (First, Middle	, Maiden Sumam		
ld be ld be ked o	To Be	Simon Glatstern					Amelia	Warsaw	7		
Maryland 21215-0030 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural, or traumatic event, the Medical Ensir	-	19a. Informant's Name/Relationship (7	Type, Print)	196.	Mailing Addre	ss (Street an	d Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)
and 2 and 2 n a 27 i		Stanley Palumbo /	Son	11:	205 Mar	rcliff			, Maryla	and 2	0852
altimore, rmit. Pages 1 ar partment of Hea portant: If Nem: y injury or other	2	20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from Sta	20b. Place of cemetery  Gdn of	, crematory o	r other place)		Date /2006	20c. Location -	•	wn, stete Ma <del>ry</del> land
injur	Ď	21. Signature of Funeral Spryice Licen		Gun Gr	22. Name	and Address	of Facility <b>Hin</b>	es Rina	ldi Fune	eral	Home
D Ped F		town !	Lews	~	1180	0 New 1	Hampshir	e Ave S	Silver Sp	ring	, MD 20904
Cate be executed Examination of the buriar-transit site buriar-transit	4.	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (	umonia, A as a consequence o phagic as a consequence o entia as a consequence o	vf): 	ion					
Hecords, P.O. box by The law requires that the death certificat Ite has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ★★No 9 □ Unknown		2 Fetal death	3 □Ectopio 5 □ Other	, ,			23d. Dai Mo	te of delive	ory Day Year
Cords, P. v requires that been signed by	by	Part II. Other significant conditions of Hypertension	contributing to deat	h but not resulting in	the underlyin	g cause giv <i>e</i> n	in Part I.				ne cause of death?
	Completed								opsy ormed?	orior to co death?	psy findings available mpletion of cause of 2 No
OT VITAL Physician: The This certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Dea			as (Canail	
- × v	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,			28c. Injury a Work?	4 Vursing H		how injury occur		//
is the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of	Injury - At home, far, etc. (Specify)	rm, street, fac	tory, office			(Street and Numb own, State)	er or Rura	il Route Number,
Hospital 24 hours a Funeral I	edical C	29a. Certifier (Check only one)  1	nysician: To the be niner: On the basi and manner	est of my knowledge s of examination and stated.	, death occurr d/or investigat	ed at the time ion, in my opi	, date and place nion, death occu	, and due to the rred at the time	cause(s) and ma , date and place,	anner as s and due to	tated. the cause(s)
To the P within 2. To the Complet	₩ W	29b. Signature and title of certifier		<b>\</b>		29c. License	number		29d. Date signe	d (Month,	Day, Year)
2-1		) / m		3		D3557	19		March 1	3, 20	006
V (	0	30. Name and address of person who							_		
		Susan J. Miller,	M.D. 684	44 Tulip I	Hill Te	errace	Bethesd	a, Mary	1and 208	376	
Regis	State strar	31. Date filed (Month, Day, Year) MAR 14	2006 S	istrar's Signature	Agen						

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	•		Depa	artment of H rtificate of L	ealth and M	ental Hyg	iene	06	0966	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  John William Finn						2. Date of Deat Month March	h 124	2006°	3. Time of 6:40	Death A M
*	/Medio Examin		4a. Facility Name (If not institution, give st. Homewood Nursing Ho				4b. City, Town, or Willian	Location of Death		4c. C	ounty of Death Washin		
v William	Funeral Director		214-09-1094	7. Age	(In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/10/1	Year)	9. Birth	place (State on ntry)  DC	or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Washington	n	10c. City, To	erst						10d. Inside Ci 1 <b>∑</b> Yes	ity Limits 2 🗌 No
	with the a or 28.	Direc	10e. Street and Number 1041 Saint Clair St	treet			10f. Zip Code 21742		1	0g. Citize	n of What Cou	intry?	
336	be filed within 72 hours after deeth with the Maryland bylygiene. Bylygiene dither than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, ite Medical Examinar must be notified at	by Funeral Director		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: W.		
Maryland 21215-0036	within 72 hou iene. 'than "natura it e Meoleal E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5-		(Give life.		ation during most of worki ) 1 Enginee			of Business/li ufactur		
/land 2	ed tal	To Be C	17. Father's Name (First, Middle, Last)  John Michael Finn					18. Mother's Name Ethel M	ay Cleme	ents			
Mar	s 1 and 2 should if Health and Men Item 27 is marke other trsumatic		19a. Informant's Name/Relationship (Type Ellen E. Burns / N.		11	96. Maili 37 B	ng Address <i>(Street :</i> Lackwatch	and Number or Rura Trail, F	airport	City or NY	14450	p Code)	
altimore,	Pages 1 and 2 nent of Health int: if Item 27 iry or other tra		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	moval from State	ceme	itery, cre	osition (Name of matory or other place 1n Cemete	ry 03/18			ation - City or T		
Balti	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service Lic	X	5	) 2	2. Name and Addres	ss of Facility Ge tomac Str	rald N.				
	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each lip	nau	MOI		g, such as cardiac o	or respiratory arr	est,		Approximat Interval Bet Onset and	tween
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a									
3760,	ate be executed hysicien and the burial-transit	ca	that initiated events c. c. resulting in death) Last	Due to (or as	a consequenc	ce of):							
P.O. Box 68	The law requires that the death certificate tie bes been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Sc. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal dea	ath 3	□Ectopic pregnancy □ Other (specify)			23	d. Date of deli Month		Year
	w requires that been signed b should be deta	b	Part II. Other significant conditions cont	tributing to death bu	at not resultin	g in the c	underlying cause giv	en in Part I.	23e. Did to		e contribute to No 3 ☐ Pro		death? Unknown
Division of Vital Records,	The law recate hes because 2 sho	Completed	Avial F. 3/1/47	la h					24a. Was a autop perfor 1 🗆 Yes	sv	death?	topsy findings ompletion of c	available ause of
Vita	rsician: s certific director,	To Be	2 . as case referred to dical examiner?	ospital:	nt 2□ER/	Outpatie	ent 3 DOA Cth	er: 4 Nursing Ho	n (Check only or me 5 ☐ Resid		Other (Spec	eifv)	
ion of	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death 11 Natural 5 Pending Accident Investigation	28a. Date of Injui (Month, Day	y 28i	b. Time o	of 28c. Injur		28d. Describe h				
Divis	tel or Atters as after desal Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home c. (Specify)	, farm, st	treet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Nur	nber,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of ier: On the basis of and manner sta	examination	dge, dea and/or in	nvestigation, in my o	pinion, death occur	red at the time, o	date and	place, and due	to the cause(	s)
)	To To con	Σ	29b. Signature and title of control				29c. Licens	26 800		Male Market	signed (Mont)	( CCC	76
54	-15		30. Name and addjets of person who co	124 10	MNSS	lu	ria Ah	enue l'	tagens	leu	um	1217	42
	Sta Regist		31. Date fied (Morlin, Day, Year) MAR 17 20	06 32. Registra	ar's Signatu <i>l</i> e	. /	lack!		J			¥ .	

DHMH 17 Rev 1/2001

John William Finn 3-14-06 642

ORIGINAL

			riease i			partment of h		-	_	DIC.		
			For Stata	State of Ma	-	ertificate of			7111	16	1196	70
			Registrar  1. Decedent's Name (First, Middle, Last)			ertineate or	Dealit	2. Date of Dear	ng. No: 💛 🖟	. (2)	3. Time of	Death
п	Physicia			Francis.	I Greene	, O.S.F.S		Month	21 2	Year 2006	1835	Рм
	/Medio		4a. Facility Name (If not institution, give s		o. oreene		r Location of Deat		4c. County		12000	
1	Examin	er	Annecy Hall	,		Childs	3		Cec	il		
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda		If Under 24 Hrs Hours Min.				lace (State o	r Foreign
	Director		230-74-9995	<sup>M 2□F</sup> 86	Yrs.	Wioning Days	110013	OCT 1,	1919	Pen	nśylva	nia
	pur *	}	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside Cit	ty Limits
	Aaryii sho ed al	5	Maryland Cecil		Childs						1 🗌 Yes	2 <b>X</b> No
	28a-	rect	10e. Street and Number		0.122.00	10f. Zip Code		1	0g. Citizen of \	What Cour	ntry?	
	3a or	Funeral Director	1120 Blue Ball R	oad		21916			Unite	ed Sta	ates	
	death	nera		12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-		e - Americ		
ဖွ	or fre		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X N	0	1 ☐ Yes 2 🔀 No		to ribari, oto.,	Specifi	v•		
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or flems 23a or 28a-f show event, the Madical Examinar must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:						Wh	ite	
5-(	"nati	ete	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. De	cedent's Usual Occup ive kind of work done a. DO NOT use retire	oation during most of wo d)	erking	16b. Kind of B	usiness/in	dustry	
12	withir iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	riest/Libr			Reli	gion		
	filed Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)			11000, 2101		me (First, Middle,				
lan	ould be Mental arked o	To Be	Anthony Joseph Gre	eene			Margare	t Agnes	Devlin			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	-	19a. Informant's Name/Relationship (Ty	рө, Print)	19b. M	ailing Address (Street	and Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)	
	s 1 and 2 f Health a Item 27 Is other tre		Oblates of St. Fran	cis de Sal		) Kentmere						06
Baltimore,	ges 1 and 2 should t of Health and Mer i If Item 27 is marke or other treumatic		20a. Method of Disposition	emoval from State	20b. Place of Dis	sposition (Name of crematory or other pla	сө) Marc	ch 24,	20c. Location	- City or To	own, State	
Ĕ	집 등 분									s, Ma	ryland	
Salt	permit. Departr Importe any inju		21. Signature of Funeral Service License	30	1	22. Name and Addre	ess of Facility For Fun	erals, P	.A.			24200
_	205 g a		- Done do	Huko		103 W. Sto	ckton St	reet, Ell	kton, M	aryla		
8			23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	re cause on each lin	the death. Do not	enter the mode of dyi	ng, such as cardia	c or respiratory an	est,		Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Chron	ic obst	notice p	ulmon	417	Aiseus		304	ens
	/Medical Examiner		resulting in double)	Due to (or as a	a consequence of):			0				
		<u>-</u>	Sequentially list conditions,	Due to for as a	a consequence of):					-		
1/	uted 1 Insit	in	Sequentially list conditions, 1 any 1 and 1 mm adults cause. Enter Underlying Cause (Disease or injury									
,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
760,	ysicia y bur	cal		d								
68	ntifica ng ph as th	Med	IS SEMALE.									
Вох	th certendir	an/h	23b. was decedent pregnant	3c. If yes, outcome 1□Live birth		3 ☐Ectopic pregnand	:y			ate of deliver	-	Year
	e dea	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (specify)					,	
P.0	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as th	Phy	Part II. Other significant conditions con	ntributing to death bu	it not resulting in th	e underlying cause g	ven in Part I	23e. Did to	bacco use con	tribute to t	he cause of c	feath?
Ś,	ires ti signe	l by	r art II. Other significant conditions con	Kilbutaing to dodari of	at not rooming in th	o and onlying out 30 g.	* O		es 2 No			
Records,	w requires to been signer should be	Completed						24a. Was	24h	Wara auto	psy findings	availahla
3ec	The law ate has l	Пр						autop	med2	prior to co death?	mpletion of c	ause of
a			25. Was case referred to medical				CC Place of Do	1 ☐ Yes		1 🗌 Yes	2 No	
Vital	Physiclan: r this certific ral director,	o Be	avaminar?	Hospital:	nt 2□ER/Outpa	tient 3 DOA Ot	han	Home 5 Aesid		her (Specia	(v)	
of	0 - 10	n: To	27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of 28c. Inju		28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ion	Attending For death.  ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	/ Year) Inju		Yes 2□No					
Division of	er des recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home, farm	street, factory, office		28f. Location (S City or Tow		ber or Run	al Route Num	nber,
D	rs after rs after or set Dir	Cer		ļ								
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification:	(Check only 2 Medicel Exami	ner: On the basis of	examination and/o	eath occurred at the t r investigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s	5)
	thin 24	Med	one) 29b. Signature and tipe of certifier	and manner sta	ited.	29c. Licen	se number		29d. Date signe	ed (Month.	Day, Year)	
	To To	-	255. Signature of the of Continer	4 // X	n		0005526		March			
			30. Name(and address of person who ca	ompleted cause of d	eath (Item 22a) (Tu		0000020		1 caron	/	-	
	10		Christine E.K. Hor				a Nowarl	r Dalawa	ro 1071	1		
	Sta	ate	31. Date filed (Month, Day, Year)				11 INCWALL	· DETUMA	15 19/1			
	Regist	ar	MAR 2 9 21	306 Dece	ar's Signature	9084E						

State of Maryland / Department of Health and Mental Hygiene 0967 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 12, 2006 1:30A GUNTOW MARCH VIVIAN IRMA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES FORESTVILLE 3001 PARKLAND DRIVE 8. Date of Birth (Month, Day, Year) SEP. 14, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months Hours 1□M **XX**F Yrs 79 1926 WASHINGTON, DC Director 579 30 7813 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at XX Yes 2 □ No Director FORESTVILLE MD PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 PARKLAND DRIVE 20747 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZM No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💹 No Specify Specify: WHITE ģ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH PRIVATE CASHIER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) STEWART CORRINE (UNKNOWN) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELMER GUNTOW / SON 3001 PARKLAND DRIVE FORESTVILLE, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 03/16/2006 SUITLAND, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **EMPHYSEMA** Sequentially list conditions, is any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequetive of). Examine and I-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): as the burial-P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, eq pinous 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ANXIETY 24a. Was an autopsy performed? has 1 Yes CORONARY ARTERY DISEASE or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XX Yes 2 □ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury XXNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital within 24 hours a Hospital 🚻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D54547 MARCH 13, 2006 PHYSKIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 VAN DUSEN RD. #350 LAUREL, MD 20707 WILLIAM J. CRITTENDEN, MD MAR 1 4 2006 32. Registrar's Signature State Registrar

			For State		•		artment of H		ınd Me	-	1		096	72
100	CARLON NO.		1 - State Registratamend #12  1. Decedent's Name (First, Middle, L	Per FH G8	55 5/04	\06~&	Milcale Of	Dealli	2	. Date of De			3. Time of	Death
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			2623 Marker Road  5. Social Security Number 6.	Sex 7	. Age (In yrs. las		Middletov		24 Hrs o	Date of Ris		ederick		
n	Funeral Director		400-26-9765	1X M 2□F	. Age ( <i>in yrs. las</i>	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da	y, Year)	922 Ken	thplace (State of ountry)	r Foreign
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	ehow	ō	10a. State 10b. County		10c. City, 1								10d, Inside Cit	, -
	the A	Directo	Maryland Frederi  10e. Street and Number	ck	Midd1	etown	10f. Zip Code				10g. Citi	zen of What Co		
	th with	alDi	2623 Marker Road				21769				USA			
	leme leme	Funeral	11. Marital Status	Armed Forc		13. \	Was Decedent of H	ispanic Orig	gin? (Specif , Puerto Ric	v Yes or No		14. Race - Ame Black, Whit		
36	rs afte	by F.	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If YAS Give	<del>™</del> ∾ s:1942–4	6	1 ☐ Yes 2 🗓 No	Specify:				Specify:		
9	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "neturel", or Iteme 23a or 28a-f ehow event. The Madical Examinar must be notified at event.	ted	15. Decedent's	Education		16a. Deced	dent's Usual Occup				16b. Ki	M N. nd of Business	Lte Industry	
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anc	0 7 5	o Be												
Maryland 21215-0036	should be ind Mental I	ပို	Walter Ignatius ( 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			oute Number			Zip Code)	
	and 2 ealth a n 27 li		William T. Green	well, son			Marker Ro	oad, M			Mar	y1and	21769	
altimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3	☐Removal from St	ate cem	netery, cren	sition (Name of natory or other plac	. 1	Date		20c. Lo	cation - City or	Town, State	
<u>=</u>	it. Pa irtmen irtant: njury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Circ		Smit		g Cremat						Cremato	
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ŀ	Physician		23a. Part1. Prier the disease, or conshock, or heart failure. List on Immediate Cause (Final	mplications that cau y one cause on eac	used the death. ch line.	Do not ente	er the mode of dyin	g, such as	cardiac or re	espiratory a	rrest,		Approximate Interval Bety Onset and D	ween
k w	/Medical		disease or condition resulting in death)		nsonism ras a consequer								Years	
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o	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a consequer	nce of):								
8760	death certificate be executed e attending physicien and of or use as the burial-transit	dicai		d										
9 X	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnance	У						23d. Date of de	livery	
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	es ti igne be c	þ	Part II. Other significant conditions	contributing to dea	th but not resulting	ng in the ur	nderlying cause giv	en in Part I.			obacco u Yes 2§		o the cause of de robably 4 ⊟U	
S	w require been sig	letec								24a. Was				
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<u>ra</u>	ian: rtifica stor, p	BeC	25. Was case referred to medical examiner?					26. Place	of Death (C	1 □ Yes Check only o	2 <b>X</b> No ле)	T Tes	2 □ No	
<u>&gt;</u>	Physic this ce	P	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inp			t 3 DOA Oth	er: 4 □ Nur				6 □Other (Spe	cify)	
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Division of Vital Records,	r Attencer death	ertification:	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	f Injury - At home	e, farm, str	eet, factory, office						ural Route Numi	ber,
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	le		Allen J. Gilson,	MD . 1475		, , ,, ,	e, Frede	rick	Marul	and	2170	2		
	. sta		31 Date filed (Month Day Veac)	32 Reg	gistrar's Signatur	e A	N a	وكلائيدي	riar y l	Lallu	41/0	4		
	Registra	ar	MAR 2 9 21	JUb Com	ACO SE	15,00								

			1 - For State Registrar	State of Maryland / D	epai Cert	rtment of He	ealth an Death	d Mental	Hygier Reg. I	tion with any artists	09673
	•	- \$0° -4	Decedent's Name (First, Middle, Las	t)					of Death		3. Time of Death
Н	Physici /Medio		SANDRA 1	OUISE GREENLEE				Mar.		Day Year 06 2006	8:06 P M
).	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or I	ocation of D			4c. County of Dea	
			NATIONAL NAVAL MEI	DICAL CENTER		BETHESDA				MONTGOME	ERY
	Funeral		Social Security Number     6. Security Number			If Under 1 Year Months Days	If Under 24 Hours N		of Birth	9. Bir	thplace (State or Foreign ountry)
L	Director		317 72 0710	<sup>□ M 2</sup>	rs.	Days	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1-195		shington,DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Loca	ation					10d. Inside City Limits
	daryl f aho	ŏ	Maryland Prince Ge								¥XYes 2 □ No
	the /	ect	10e. Street and Number	orge b Deret	,,,,	10f. Zip Code			10g (	Citizen of What C	ountry?
	with 3s or	Funeral Director	11939 Beltsville	Drive			705			USA	ountry.
	Jeath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	as Decedent of His		(Specify Yes	or No-	14. Race - Am	erican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f ahow eny injury or other traumatic event, the Medical Examber into the Incillied at once.	by Fur	1 ☐ Never Married   3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	lf 1	Yes, specify Cuban □ Yes 2 <b>1</b> No	, Mexican, Pe Specify:	uèrto Rican, et	c.)	Black, Whi	te, etc.
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Nar	2 sh and ls m raum		19a. Informant's Name/Relationship (7) Charles E. Green	1 /1 1 1	-	Address (Street ar					
	is 1 and 2 of Health al item 27 Is other trau			20b. Place of D		Beltsvi	IIe Dr	. Belt	_	<del>-</del>	20705
Baltimore,	iges or of		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	, crema	atory or other place,	2/	15/2006		Location - City or Itland, N	
ij	t. Pa rtmer rtant njury		' 4 □Donation 5 □Other (Specify		_	em.Cemete			, 30	ircraild,	
Ba	permii Depar Impor eny ir		21. Signature of Funeral Service Licens Mary E. Audop			Name and Address	-	. 4111	Penn.	,Ave. Sι	20746 iitland, Md.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do no	ot enter	the mode of dying,	such as car	diac or respirat	ory arrest,		Approximate Interval Between
	Friysician	i II	Immediate Cause (Final disease or condition	Metastatic Breast	: Ca	ancer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	f):						
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	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	1):						
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687	ficate physis the	edical		d							
Box (	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy						23d. Date of de	livery
ď	death s atte d for	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		ctopic pregnancy Other (specify)				Month	Day Year
P. O.	t the by the ache	hys	9 Unknown	9□ Unknown							
	res that igned b	by P	Part II. Other significant conditions co	ntributing to death but not resulting in t	the und	derlying cause given	in Part I.	23e.	Did tobacc	o use contribute t	the cause of death?
ğ	w require been sig should b							_	1 🗌 Yes	2 1 No 3 □ P	robably 4 Unknown
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æ	The lav ite has vage 2	Completed						10	autopsy performed? res 2 121	prior to death?	completion of cause of : 2□ No
ij	ysician: The l is certificate ha director, page	BeC	25. Was case referred to medical				26. Place of	Death (Check		10 10	20110
>		To	examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2 ER/Outp	atient	3□ DOA Other	4 ☐ Nursin	gHome 5□	Residence	6 □Other (Spe	cify)
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<u>Si</u>	andi eath. or: A the fu	catl	2 ☐ Accident investigation				es 2 □ No				
Division of Vital Records,	in Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	n, stree	et, factory, office		28f. Locat City o	ion (Street or Town, Sta	and Number or R ate)	ural Route Number,
	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge,	death o	occurred at the time	, date and pl	ace, and due to	the cause	(s) and manner a	s stated.
	0 0 0	edical	(Check only 2 Medical Exam	ner: On the basis of examination and/ and manner stated.	or inve	stigation, in my opin	nion, death o	ccurred at the	time, date a	ind place, and due	to the cause(s)
	To the within To the compl	M	29b. Signature and title of certifie	1/1/1	1	29c. License	number		29d. 0	Date signed (Mont	h, Day, Year)
	61		Lywa AX	trance III	1	D-528	362		3	-14-2	.006
)	14)		30. Name and andress of person who a	impleted cause of death (Item 23)	ype, Pr	7.00	T-10	val Med			
	$\odot$		Kevin & Dorrance							389-5600	
	Sta	- 11	31. Date filed (Month, Day, Year)	32. Registrar's Signature			,	, _ J			
	: Registr	ar	MAR 1 5 2006	Bearing # 60	200	9					

			1 - For State Registrar	State o	f Marylar	•	artment of H rtificate of		nd Mental H	ygiene Reg. No	.000	09674
	Physici		1. Decedent's Name (First, Middle, Roderick Cli		Gray				2. Date of I Month March	Da	2006 Year	3. Time of Death 10:04a M
į	/Medic Examir		4a. Facility Name (If not institution,	3	m <i>ber)</i>		4b. City, Town, o			4c	. County of De	ath
4			Holy Cross Hos		7 Ann //n	for a facinetical and	Silver If Under 1 Year	Sprin		N: 15		gomery
	Funeral Director		5. Social Security Number 075-10-1439	6. Sex 1 M M 2 □ F	7. Age (In yrs. 87	Yrs.	Months Days		Min. 8. Date of B (Month, I July	Day, Year) 24,	1918 N	irthplace (State or Foreign Country) Iew York
	pu \star :		Usual Residence of Decedent  10a. State 10b. County		100 Ci	ty, Town or Lo	action					404 1-14-05-11-1-
	Aaryla f sho	5										10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	Director	Maryland Montgo	omery	S1	lver Sp	10f. Zip Code			10a. Cit	tizen of What C	
	h with	<u>=</u>	9900 Georgia	Avenue, #	709			-5243			USA	
	deati	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of F	lispanic Origin	n? (Specify Yes or I Puerto Rican, etc.)	No-		nerican Indian,
2	72 hours after death with the Maryland Instural', or Items 23s or 28s-f show disal Examiner must be notified at	by Fu	1 Never Married 2 Marrie	d 1 🔼 Yes If Yes, Giv	<sup>2</sup> □No W	.T.T.T	1 ☐ Yes 2 🖾 No	Specify:	derio riidari, etc.)		Black, Wh	hite hite
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7	od with	E O	12	College (1	1-40( 5+)	Bu	s Driver			Tran	nsporta	tion
and	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, L.						s Name (First, Midd	le, Maiden	Sumame)	
2	J Men narke	은	Edgar Russell						na Rose			
2	d 2 st th and t7 is r traur	l (	19a. Informant's Name/Relationshi Elizabeth Mulle		life				or Rural Route Num e, #709,			
ā,	s 1 and 1 Heal		20a. Method of Disposition			Place of Dispo	sition (Name of	1	Date	20c. Lo	ocation - City o	
altimor	Page nt: = 1		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other plai in Cremator		rch 12, 2006	Ale	exandri	a, Virginia
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee	عر _				ns Funera lvd, W, S			g, MD 20901
Н			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that c	aused the deat				<u></u>		L SPIIII	Approximate
ار	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myoca	rdial		ion					Interval Between Onset and Death Immediate
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Ų.	The law requires thet the death certifi site has been signed by the attending page 2 should be detached for use as	by Pi	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Dio	tobacco u	use contribute	to the cause of death?
cords,	w require been sig should b								10	Yes 2	□No 3□F	Probably 4 25 Unknown
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= =	ding Physician: The h. h. After this certificete his funeral director, page	Con							neq	förmed? 2 🔯 No	death?	s 2 No
5	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or	Death (Check only			
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	el or Atte s after de il Directo id in by th	Certification;	3 Suicide 6 Could no determin	ed 286. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or To	(Street an own, State	nd Number or F	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours atter death. To the Funerel Director: After this certifice, completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the caminer: On the ba and mann	isis of examina	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and p pinion, death	place, and due to the	e cause(s) e, date and	) and manner a d place, and du	as stated. le to the cause(s)
	Withii To the comp	W	29b. Signature and title of certifier	1	1	2	29c. Licens	e number		29d. Da	te signed (Mon	nth, Day, Year)
	140		· S		- 11	D	D52	503		Ma	arch 11	, 2006
1			30. Name and address of person we Shailesh Sheth,					Silve	r Spring,	MD 1	20910	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa		all loud,	~	- Spring,	110 2		
	Registr		MAR 14	2006	Lacres &	O P	No. Comments					

		1 - For State Registrar		Maryland /		tificate of			Reg. No	.UUD	09675
Physi	cian	Decedent's Name (First, Middle	, Last)					2. Date of De Month	Da		3. Time of Death
/Med	lical	JEANNE	GEVINS			4b. Ch. Tour	-1 2 75 0	MARCH 1			5:45 P M
Exam	iner	4a. Facility Name (If not institution, MONTGOMERY HOSPICE	-			ROCKVILI	r Location of Deatl Æ	1		County of Death MONTGOMERY	
Funera	1	5. Social Security Number		Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth		ace (State or Foreig
Directo		469-26-4314	1 □ M 2 □ ¥F	76	Yrs.	Months Days	Hours Min.	8/25/1	925 <sup>ear</sup> ,	MINNE	lace (State or Foreig
pu ,		Usual Residence of Decedent  10a. State 10b. County		10- 01- T-							
aryla ehov	5		MEDV	10c. City, To						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N	Directo	MARYLAND MONTGO  10e. Street and Number	MEKI	SILVE	SPR	10f. Zip Code			*0= 0	200	
with with			тоггт			20906			USA	tizen of What Cour	itry?
death me 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		14. Race - Americ	an Indian.
be filed within 72 hours after death with the Maryland ital Hygiene. In the work of other than "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be redified at	2	3 ☐ Widowed 4 ☐ Divorced	Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	ĽŽNo		FYes, specify Cuba I□Yes 2 No	an, Mexican, Puèrt Specify:	o Rican, etc.)		Bleck, White, Specify: WHIT	etc.
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be fill	Be	17. Father's Name (First, Middle, L MAX JAFFE	ast)				18. Mother's Nan SOPHIE	ne <i>(First, Middl</i> e UNKNOWI		Sumame)	
thould be ind Menta marked matic ev	P	19a. Informant's Name/Relationsh	in (Time Defeat)	1	No. 14-11-						
permit. Pages 1 and 2 should be filed v Deperiment of Heelth and Mental Hygie Importent: If Item 27 is marked other in mit Jnjury opgither traumatic event, the		MORRIS GEVINSON -					STREET; SI			or Town, State, Zip	Code)
nit. Pages 1 and 2 should entment of Heelth and Men ortent: If Item 27 is marks Injury or other traumatic		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of		Date		ocation - City or To	wn, State
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The te h	E							autor perfo	rmed?	prior to con death? 1 \( \sum \text{Yes} \)	npletion of cause of
sician: The la certificate ha lirector, page 2	Be C	25. Was case referred to medical examiner?					26. Place of Dea			12.103	26410
hysic lidire	2	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	atient 2 ER/C	utpatien	3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 ☐ Resi	dence	6 Other (Specify	HOSPICE
ding Physician: th. : Atter this certifice situneral director, p	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of I	njury 28b. Day Year)	Time of Injury	28c. Injun World	at c?	28d. Describe I	how inju	ry occurred	
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To the Hospitel or Attending Physician: within 24 hours effer death.  To the Funerel Director: After this certifical completely filled in by the funeral director.	edical Ce	29a. Certifier 1 X Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	s of examination a	je, death nd/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s)	) and manner as sta d place, and due to	ated. the cause(s)
o the o the omple	Med	29b. Signature and title of certifier	and manner	ડાતાઉપ.		29c. License				te signed (Month, L	
F 3 F 8		1	1/	MI		D356				H 13, 2006	/· · -=-/
5		30. Name and address / perso w	no completed cause of	of death (Item 23a)	(Type I	Print)					
		JOSEPH KAPLAN M.D		CASTER MILI			LE MD 2085	5			
S	tate	31. Date filed (Month, Day, Year)		strar's Signature	R.	and s					

			1 - For State Registrar	State of Maryl		artment of H rtificate of L		F	Reg. No.	09676
W A	Physici /Medic		Decedent's Name (First, Middle, Las     Michael Robert Gu					2. Date of Dea Month March	Day 1 Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, gives  Washington Cour  5. Social Security Number 6. Se	nty Hospital	yrs. last birthday,	If Under 1 Year	rstown If Under 24 Hr	s. 8. Date of Birth	h 9. Birtho	on County  Diace (State or Foreign
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	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Coul	ntry?
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *netural', or Iteme 23e or 28a-f show any figury or other traumatic avent. The Medical Exalt art must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Pue	Specity Yes or No- orto Rican, etc.)	Black, White,	
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7	be filed w stal Hygier ad other ti		17. Father's Name (First, Middle, Last)		<u> </u>	ntractor	18. Mother's N	ame (First, Middle,	General Con	itractor
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altimore,	Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 🗆 Burial 2 🖫 Cremation 3 🗆	Removal from State	Ob. Place of Disp		e)	Date	20c. Location - City or T	own, State
Baltin	permit. Pa Departmer Important any injury		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		2	2. Name and Addres	ss of Facility	Douglas A	. Fiery Fund	eral Home
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				40)14		1210	157		5-17-20	106
Á	4-3		30. Name and address of person who ABOUL WAHE	completed cause of death	(Item 23a) (Type	OAKHI(	AVE,	HAGERS	3-17-20 stown. MD-	21742
1000	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	perter				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perfs. (85%, 4/5/06 TT)

State of Maryland / Department of Health and Mental Hygiene (1) (5) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March Physician  $0^{Day}$ 2006 3:55 Ам Hawkins Jesse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 92 Director March 23, 1913 DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits X Yes 2 No Funeral Director DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20018 USA 3005 Bladensburg Road NE #516 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates1942-1945 1 Never Married 2 Married 1 Yes 2 No Completed by SpecifyBlack 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Gordon Jesse Nathaniel Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 Ridge PL SE Washington DC 20010 Vernon Hawkins - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If sny injury or once. 3/9/2006 Landover, Maryland Harmony Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility Pope Funeral Home (C) .-2617 Pennsylvania Ave. SE Washington DC 20020 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Acute Renal Failure 1 ∏ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Pneumonia 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ 1/0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

or Attending Physicien: The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

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Hospital

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erment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Iteme 23a or 28e-f show injury or other traumatic svent, its Mexical Examinar must be certified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Ite

Maryland 21215-0036

Baltimore,



31. Date liled (Month, Day, Year) MAR 1 4 2006

Sabyasachi Kar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MD 063703

March 10, 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 2006 12:33P Martha Hunt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 11, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🔼 F 57 Yrs. Alabama 1948 416-66-4381 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at Silver Spring 1 X Yes 2 No Maryland Montgomery Director 10f. Zip Code **20906** 10g. Citizen of What Country? et and Numbe 4504 Randolph Rd. United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 점 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than "r r traumatic avant, "ne Med College (1-4or 5+) Elementary/Secondary (0-12) Job Coach Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Wiley Joseph Gant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4504 Randolph Rd.; Silver Sprign, Md. 20906 Danielle Gillon/Daughter other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Metropolitan CrematoryMarch 10, 2006 Alexandria, VA. 4 □ Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician months Metastatic Lung cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (University and Instituted Augusts) Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Cause (Disease or inju that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 🖸 No certificate the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one. Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 1 ☐ Yes, 2 No 3 DOA Certification: To this After th Date of Injury (Month, Day Year) r of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending M 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Le Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 8, 2006 D50987 8-3 30. Name and address of person who completed a se of death (Item 23a) (Type, Print) Ahmed Nawaz, P.O. Box 83819; Gaithersburg, MD. 20883 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Peter Joseph Hayes March 8, 2006 11:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | tf Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 150 M 2□F 90 Yrs. Director 219-01-8165 Aug. 18, 1915 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show eny Injury or other treumatic event, the Medical Examination must be notified at once. 1 TxYes 2 □ No Maryland Montgomery Gaithersburg Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20877 United States 109 Rolling Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper & Sales 8 Tire Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linwood Hayes Eloise Gott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peter Steven Hayes/Son 11204 Minstrel Tune Drive, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition March 13, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Oak Cemetery Gaithersburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific respiratory arrest, a full control of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific respiratory. Immediate Cause (Final esp Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonici Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physicien and the for use as the burial-transit SUS Exami that initiated events resulting in death) Last The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 [] Unknown Part II. Other significant conditions pontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ter death. Irector: After this by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the I D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medita lente Do Rockville, MD 20850 50) State 2005 Registrar

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Ž	a distance a series a		Miriam D. Bizzarr	o (Sister	) 2	906	87th Ave.	Par	rrish	ı. FL	342	19-0000		
נֿע	Hee tem		20a. Method of Disposition	(3_3	20b. Place	of Dispo	sition (Name of	T	Dat	- 4		cation · City or To	own, State	
2	ages int of t: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State			ris & Co.		/27/0	16	West	Chester	· PΔ	
	it. Portme		21. Signature of Funeral Service Licens	20	11.								, IA	
0	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelith and Mantal Hydiene.  Department of Heelith and Mantal Hydiene.  Important: If them 27 is marked other then "naturel", or theme 23a or 28a-f show eny injury or other treumatic event, the Martical Examiner must be notified at once.		Mara C.	Bellmi	10	Î	Name and Address arring—Ca berdeen,	rgo Fu Marvla	inera	1 Hom	e P.	A. 9		
			23a, Part1. Enter the disease, or compl	cations that caused	the death. D								Approximate	
١,	<b>2</b> 1		shock, or heart failure. List only or Immediate Cause (Final				~~~						Interval Between Onset and Death	
'	Physician /Medical		disease or condition resulting in death)	CUTE I	NFEN	OLA	FIENAL	MYOC	ANG	DIAL.	2	PARCION	)	
	Examiner			Due to (or as a	a consequenc	e of):								
		e	quentially list conditions, b											
	nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_ `										
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j	he d the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	unio di doam	3_	Other (specify)							
Ľ	that t		Part II. Other significant conditions cor	ntributing to death bu	it not resulting	in the u	nderlying cause give	n in Part I	_	23e. Did to	obacco u	se contribute to t	he cause of death?	
'n	sign sign d be	l by		•			, , , , , , , , , , , , , , , , , , , ,				res 20		pably 4 Dunknown	
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=	ng P	ä	27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury	28c. Injury Work	at ?	280	d. Describe h	now injur	y occurred		
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2	r Atl	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	larm, str	eet, lactory, office		281	. Location (5 City or Tox		d Number or Rura )	al Route Number,	
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	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours elter death: within 24 hours elter death: To the Funeral Director: After this certificete has been signed by the estending the completely filled in by the funeral director, page 2 should be deteched for use as	Medical	(Check only 2 V Medical Exami	sician: To the best oner: On the basis of	examination :	ge, death	occurred at the time	e, date and p inion, death o	olace, and	due to the	cause(s)	and manner as s	tated.	
	the the the	Med	une)	and manner sta	ted.									
	So o o		29b. Signature and title of certifier	4 A			29c. License					e signed (Month,		
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1	$0_{4}$ ,		30. Name and address of person who co									,		
١			31. Date liled (Month, Day, Year)	(-0) 23	336	101	ic no	1140	216	MI	10)	21093	<b>.</b>	
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	Registr	ar	MAR 2 9 200	O PARAGE	1 15	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 12:23 PM March Catherine Louise Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Homewood at Williamsport Williamsport If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 10/17/1904 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🕱 F 101 215**-**14-2301 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or Items 23s or 28e-f show treumstic event, the Medical Examiner must be notified at 11 Yes 2 □No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 US 425 Guilford Avenue Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Florence Needy Jacob Frederick Sowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16628 Buford Drive, Williamsport, MD 21795 permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
any injury or other treu Paul D. Wade / Great-nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Paul's Cemetery 03/20/2006 Clear Spring, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHan! **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year ned by the at detached fo 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknow been signed t should be det 23e. Did tobacco use contribute to the cause of death? Part II/Dther significan conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this neral Director: After thi filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 Homicide To the Hospitel within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur (106 2006 recoun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Pennsylvania Avenue, Hagerstown, MD 21742 (SH-2 Stephen E. Metzner, th Day, Year) MAR 2 U 2006

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

32. Registrar's Signature

			1 - For State Registrar	tate of Maryland		irtment of H tificate of L			iene og. No.	09684
, ,	Physici /Medi		Decedent's Name (First, Middle, Last)     Evelyn Jones					2. Date of Dea Month March	9 <sup>Day</sup> 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give stree Anne Arundel Medi	cal Center		4b. City, Town, or Annap	olis		4c. County of Deat	
200	Funeral Director		5. Social Security Number 6. Sex 220−86−2820 1	7. Age (In yrs. la	st birthday) 4 Yrs.	If Under 1 Year Months Days	Hours Mi	n. (Month, Day	Year) Co	hplace (State or Foreign puntry) yland
	B Maryland la-f show	ctor	Maryland Anne Arus		Town or Local					10d. Inside City Limits  ↑ Y es 2 □ No
	th with the	al Director	10e. Street and Number 228 Croll Dr.			10f. Zip Code 21401	L	1	0g. Citizen of What Co	ountry?
980	within 72 hours after death with the Maryland one. Then "natural", or iteme 23a or 28a-f ehow the Madical Examiner must be notified at	by Funeral (	XXNever Married 2☐ Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	lf	Vas Decedent of Hi Yes, specify Cubai	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene and Mental Hygiene "natural", or iteme 23a or 28a-1 show termstic event, the Maulical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12) 12th	on mpleted) College (1-4or 5+)	(Give I life. [	ent's Usual Occupa kind of work done o DO NOT use retired, retaker	ition luring most of w	rorking	16b. Kind of Business/ House of Care	
land	should be fifed wand Mental Hygie marked other ti	To Be (	17. Father's Name (First, Middle, Last) Unobtainable					ame (First, Middle, I ra Jones	Maiden Surname)	
, Mar	and 2 sho salth and ? n 27 le ma er traums		<sup>19a.</sup> Informant's Name/Relationship <i>(Typ</i> e, Miyoshia Williams	*	1928912 Mont	5 Milis	nd Christon Villag		City or Town, State, 2	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 le marked any injury or other traumatic evonce.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remark 1 □ Donation 5 □ Other (Specify)	cei	netery, crem	sition (Name of natory or other place UM Chur	ch 3-1		20c. Location - City or Annapolis	
Balt	Departition Depart		21. Signature of Funeral Service Licensee  Lavry B, Ree	se MOO483	Wr 82	Name and Addres N. Reese 21 West	s of Facility & Sor St. Ar	ns Mortu nnapolis	ary, P.A. , Md. 214	01
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one commediate Cause (Final disease or condition	ons that caused the death.	7	er the mode of dying	1	ac or respiratory arre		Approximate Interval Between Onset and Death
	Medical  Examiner  The private and the private	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque	ence of):					
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	ding Physician: Th h. Atter this certificate funeral director, pag	tion: To Be		1 Inpatient 2 LE	R/Outpatient 8b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing		el ence 6 Other (Spec ew injury occurred	sify)
Division	tal or Attending P s after death. al Director: After t ed in by the funere	Certification:	2 Curida 6 Could not be	Be. Place of Injury - At hom building, etc. (Specify)	e, farm, stre			28f. Location (St. City or Town	reet and Number or Ru i, State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical	one)	n: To the best of my knowl On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and plac inion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	MO		29c. License	number 518	7	9d. Date signed (Month	n, Day, Year)
			30. Name and address of perso o complete	eted cause of death (Item 2	3a) (Type F	rint)	svend	el Me	Jan 6	on ter
	Sta Registr		31. Date filed (Month, Day, Year) 14 2006	Registrar's Signatu	A A	S.		***		

		1_ For State	State of Maryland	d / Depa	artmer	nt of Heal	Ith and M	-	_	6	09685	-
		Registrar		Cer	Tillcai	e of Dea	au 1	7	g. No.		7 - 7 - 7	
Physic	cian	Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Day	Year	3. Time of Death	
/Med		Lavinia Jo						March 9			1905	М
Exam	iner	4a. Facility Name (If not institution, give st				Town, or Loca		1	4c. County			
		anne Arundel Me				apolis	Inder 24 Hrs.	9 Date of Birth	Anne			· · ·
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. Is	AST DIRTHORAY) Yrs.	Months		ours Min.	(Month, Day,			plece (State or Forei	ign
Directo	4	213-32-6362 Usual Residence of Decedent	68					Jan. 4	1938	Mar	yland	
land ow		10a. State 10b. County	10c. City	, Town or Lo	cation					1	0d. Inside City Limi	its
Mary -1 sh	to	Maryland Anne Ar	andol Anr	nanol:	ia						1 ☐Yes 2 ☐ N	No
28e	Director	10e. Street and Number	under I Auf	lapor.		o Code		1	0g. Citizen of	What Cou	ntry?	
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and and the man		19a. Informant's Name/Relationship (Typ	ne, Print)								Code) 2140	
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permit. Pages Department of P Important: If ite Anjury or of	á	21. Signature of Funeral Service License	Λ	22 TaTs	Name a	nd Address of	Facility					
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SIO tendi eath tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Yes	2   No		111			
or At fter d fter d oirect	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str ')	eet, facto	ry, office		28f. Location (St City or Town		per or Hur	al Houte Number,	
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To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, age	Medical	(Check only 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat									
thin 2 the mplei	Med	29b. Signature and title of certifie	and manner stated.		20	c. License nun	mber	2	9d. Date signe	ed (Month	Dav. Year)	
T V		Soo. Signature and title of continue	)						03/0			
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		1 -1 .	mplèted cause of death (Item	23a) (Type.	Print)						w	
180 2 0	toto	31. Date filed (Marth Bay, Year) 200	Registrar's Sign	rure -								
Regis	tate	14 200	o proper D	14								

# Baltimore, Maryland 21215-0036 BAR BARA

Box 68760

The law requires that the death certificate be executed P.O. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** MARCH 15 BARBARA O'NEAL 2006 RAE JASNOWSKI 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Year)
NOV 21, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 M 2 F 286-36-8949 Yrs. Director 66 PENNSYLVANIA Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other treumstic event, the Medical Examinar met be notified at 1 ☐ Yes 2 No Director MARYLAND CHARLES WHITE PLAINS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 4050 RAVINE DRIVE 20695 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify β If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MOTOR VEHICLE College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATION CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other treumatic event
ange. Be RAYMOND FRANCIS O'NEIL BEATRICE GRACE SEDORA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM R. JASNOWSKI - HUSBAND 4050 RAVINE DRIVE, WHITE PLAINS, MD 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MARCH 1 Burial 2 □ Cremation 3 □ Removal from State 20, 2006 ¹ 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY SUITLAND, MD M00053 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HUNTT FUNERAL HOME Bu skow tark 1. P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 12 Inpatient 9 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3-11-06 nus D-57708 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) OMAIS, MD CENNA MED. CTR. 7-C POST OFFICE RD. WALDORF, MD 20602 31. Date filed (Month, Day, Year) State

Registrar

MAR 15

2006

			For State Registrar	State o	f Maryland / Dep	partment of ertificate of			iene	09688
			1. Decedent's Name (First, Middle	le, Last)				2. Date of Death Month		3. Time of Death
	Physici /Medic			WILBU	R RAY KELL	Υ		MARCH 2		2:20 p. M
	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)	4b. City, Town,	or Location of Dea	th	4c. County of	Death
			11450 SIMMONS	RD.			EYTOWN		FREDE	RICK
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days		. (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	-	213-18-8456	IM 2LF	89 Yrs.			OCT. 18	,1916 T	HURMONT, MD.
	pu 🔹		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	sho	5								1 ☐ Yes 2 X No
	Ne N 186-f	Director	MD FREDE  10e. Street and Number	RICK	TANEYTO	10f, Zip Code		10	Og. Citizen of Wh	at Country?
	with a or		10e. Street and Number				0.7			at Country :
	hours after death with the Maryland tursi; or Itema 23a or 28e-f show al Examinar must be notified at	Funeral	11450 SIMMC		adopt Francis II.S. 1	217			U. S.A.	American Indian,
	er de item	nue	11. Marital Status  1 □ Never Married 2 □ Mar	Armed Fo	edent Ever in U.S. 13 proes?	<ol> <li>Was Decedent of If Yes, specify Cul</li> </ol>	ban, Mexican, Pue	rto Rican, etc.)		White, etc.
36	rs aft	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi	VA 41 45	1 ☐ Yes 2X No	Specify:		Specify:	WHITE
21215-0036	d within 72 hours after death with the Marylan jiene. r then "natural", or Itema 23a or 28e-f show The Madisal Examinat man ke nutitied at	edi		nt's Education	16a. Dec	cedent's Usual Occu	pation		16b. Kind of Busi	ness/Industry
15	n na	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)	life	ve kind of work done . DO NOT use retir	e during most of wo ed)	orking		
212	filed within Hygiene. other then "	E	8	College (	1-401 5+)	JANITOR			TOOL CO	•
	E ST E	Be C	17. Father's Name (First, Middle,	, Last)			18. Mother's Na	me (First, Middle, M	Maiden Surname)	
<u>a</u>	d ta b	To B		GUY KEL	LY		F	RUTH NAOM	II REC	KER
Maryland	de la Fil	-	19a. Informant's Name/Relations	ship (Type, Print)	19b. Ma	iling Address (Stree	at and Number or F	Rural Route Number,	City or Town, St	ate, Zip Code)
	1 and 2 Health a tem 27 is		STEPHEN F. KE	ELLY	114	50 SIMMON	S RD., TA	ANEYTOWN,	MD. 217	87
ē,	s 1 and f Healt item 2 other		20a. Method of Disposition		camatani c	position (Name of rematory or other pl	ace)	Date 2	20c. Location - C	ity or Town, State
Ę	Pages nent of I int: if its ury or o		1 ☑ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5		State	LD UNION	3/27	7/06 E	FAIRFIEL	D, PA. 17320
altimore,	그 든 판 중		21. Signature of Funeral Service	A	2	22. Name and Add	ress of Facility	SKILES F	TUNERAL	HOME
ä	Depar impo any ir once		Alan	C. Fur	vu	210 W. MA	IN ST., H	EMMITSBURG		
	Prrysician /Medical Examiner		23a Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	aused the death. Do not death line. (or as a consecuence of):	enter the mode of dy	ring, such as cardia	ac or respiratory arre	est,	Approximate Interval Between gnset and Death
8760,	ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to c. Due to d	(or as a consequence of):	vic v	orcara	_ Mu		cogis
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and one as should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	nant at time of death	B□Ectopic pregnan	су		23d. Date Monti	
	s tha	by P	Part II. Other significant condition	ions contributing to o	leath but not resulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
of Vital Records,	w require been sig should b	edt	recent pro	lumon	e with			1 🗆 Ye	s 2 🗆 No 3	Probably 4 □Unknown
00	law re	Completed	nein	test	humantia	_		24a. Was ar	n 24b. W	pre autopsy findings available or to completion of cause of
ä	The la	E			70			perform	ned?   de	ath? ☐ Yes 2X No
tal		0	25. Was case referred to medica	al	9_/		26. Place of De	eath (Check only on		
>	Physicien: this certificanal director,	0 0	examiner? 1 ☐ Yes 2∑ No	Hospital:	Inpatient 2 ☐ ER/Outpat	ient 3 DOA	ab	Home 5 AReside		(Specify)
of	는 F E	n.	27. Manner of Death	28a. Date	of Injury 28b. Time	of 28c. Inj	A-74	28d. Describe ho		
lon	th. : After s funer	oite	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Mor tigation	nth, Day Year) Injur		☐Yes 2☐No			
Division	Attender death	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 286. Plac	e of Injury - At home, farm,	street, factory, office	9	28f. Location (St. City or Town	reet and Number	or Rural Route Number,
Ö	al or	Sert	4   Homicide	build	ling, etc. (Specify)			Ony or roun	,, 0.0.0)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai C		Exeminer: On the I	e best of my knowledge, de pasis of examination and/or					
	thin the mple	Med	29b. Signature and title of certific	er and mar	nne/stated.	, 29c. Lice	nse number	2	9d. Date signed	(Month, Day, Year)
	F 3 F 8			Ves	Malial	IN	11871	2	MARCH 24	, 2006
	14		9	out to a constitution of the	an of death (them one) /	V V	01010			•
	10,,		30. Name and address of person				MIMODITO	ND 0170	7	
	-01	ate	31. Date filed (Month, Day, Year		310 S. SETON Registrar's Signature	AVL., EM	MITISBURG,	MD. 21/2	1	
	Regist				wans B. A	and a				

		1 - For State Registrar		Ce	ertificate of	Death	105: :=	Reg. No	JUU	09689
hysicia		Decedent's Name (First, Middle, La  F.	sı) dward Fran	k Kimball			2. Date of D Month	, Da	ay Year	/ 31 / //
/Medica Examine		4a. Facility Name (If not institution, giv		R RIMBULL	4b. City, Town, o	or Location of Death		-	c. County of Dea	
		16 Fourth Avenu			E1kto				Ceci1	
al or		5. Social Security Number 6. S 219–58–2540	6ex 7. Age □XM 2□ F 5	e (In yrs. last birthda) 4 Yrs.	Months Days	Hours Min.	8. Date of Bi	irth lay, Year 195	9. Bi	rthplace (State or Foreigr Jountry) Maryland
		Usual Residence of Decedent								
Once.	2	10a. State 10b. County		10c. City, Town or I	_ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Director	Maryland Cecil  10e. Street and Number		E1kton	10f. Zip Code			10g. C	itizen of What C	
	<u></u>	16 Fourth Avenu	e		21921			Į	Jnited S	States
	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	. Was Decedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Am Black, Whi	erican Indian,
1	by Fr	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 X N	10	1 ☐ Yes 2 🗓 No		,		0	
	ed b	15. Decedent's E	Year or Dates: ducation	16a. Dec	edent's Usual Dccur	pation		16b. h	Kind of Business	hite s/Industry
-	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	lite.	e kind of work done DO NOT use retire	during most of won d)	king	Cc	ommercia	al Media
	Con		2		wner	γ			roductio	on
1	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam				
i	٥	James E. Kimbal		19h Mai	ling Address (Street		Anna S			Zip Code)
		James E. Kimbal			Fourth Ave					
		20a. Method of Disposition		20b. Place of Disc	position (Name of ematory or other pla	ce) Marc	Date h 24,		ocation - City or	
		1 ☐ Burial 2 🕅 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of the C		R.A. Ferr	is & Co. In	c. 2006		Pe	est Ches ennsylva	nia
N N		21. Signature of Funeral Service Lice	nsee )	i	22. Name and Addre	ess of Facility Efor Fun	erals,	P.A.	983	land 21921
	-	Daniel &	- Hick	the death Densit	103 W. Sto	ockton St	reet, E	1ktc	on, Mary	land 21921
ı		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.	Inter the mode of dyl	ng, such as cardiac	1 i	arrest,		Approximate Interval Between Onset and Death
ı		disease or condition resulting in death)	a. A inte	a consequence of):	ur dial 2	nfarci	10n			minutes
1			Due 10 (01 d3	a consequence or,						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	a consequence of):						
				a consequence of):						
	olbe		_ d							
	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		OF stania aragnana	.,			23d. Date of de	alivery
	<b>©</b>	in the past 12 months? 1 Yes 2 No	4 Pregnant at		☐ Ectopic pregnanc ☐ Other (specify) _	У			Month	Day Year
11.1	SIC	9 Unknown				ron in Part I	020 034	tobacco	ueo contetuto i	to the cause of death?
	Physici		and depote the contract of the second				230. Did	9		robably 4 Munknown
	by Physician/Medical	Part II. Other significant conditions					1/2	Yes 2	_	
	à	Part II. Other significant conditions					1 A		Jah More a	utopou findingo available
	à	Part II. Other significant conditions	contributing to death be				Se 24a. Was	s an opsy ormed?	prior to death?	completion of cause of
	e Completed by	Part II. Other significant conditions				Porja	24a. Wa auto perf 1 Yes	s an opsy ormed? 2/2 N	prior to death?	completion of cause of
	o Be Completed by	Part II. Other significant conditions of the pert in Sion Massive obe		M, Hyp erigh era	erligide l vascu,		24a. Wa: auto perf 1 Yes  th (Check only	s an opsy formed? 2/2 N	prior to death?	s 2 No
0	To Be Completed by	Part II. Other significant conditions of the part in Sion Mars 125. Was case referred to medical examiner?  1 1 Yes 2 \sum No  27. Manner of Death	2, N 198	om, Hyperight era	erligide lvascu,	26. Place of Dea	24a. Wa: auto perf 1 Yes  th (Check only	s an opsy ormed? 2/21 None) sidence	prior to death? o 1 \( \text{Ye} \) 6 \( Other (Specific of the section of	s 2 No
	To Be Completed by	Part II. Other significant conditions of the perturn 5 is a second significant conditions of the perturn 5 is a second significant conditions of the perturnal second significant second significant second significant second significant second significant second significant second se	Hospital: 1 Inpatie  28a. Date of Injur (Month, Da)	om Hyperight era	erligide l vascu, ant 3 DOA Dt of 28c Inju	26. Place of Dea	24a. Wa. autr perf 1 Yes th (Check only ome 5 Res 28d. Describe	s an opsy ormed? 22 N one) sidence	o prior to death? 1 Ye 6 Other (Spa	completion of cause of s 2 No
	To Be Completed by	Part II. Other significant conditions of the part in 5,00.  Mas 55/V C DD  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpatie  28a. Date of Injur (Month, Day)	om, Hyperiphera  ont 2 ER/Outpatin  (Year) 28b. Time Injury  ury - At home, farm, s	erligide l vascu, ant 3 DOA Dt of 28c Inju	26. Place of Dea	24a. Wa. autr perf 1 Yes th (Check only ome 5 Res 28d. Describe	s an opsy ormed? 2/21 None) sidence how inju	o prior to death?  1 Ye  6 Other (Sparry occurred	s 2 No
	Certification; To Be Completed by	Part II. Other significant conditions of the perturbation of the p	Hospital:   Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ont 2 ER/Outpatility  Year)  28b. Time Injury  At home, farm, s.  (Specify)  of my knowledge, dealexamination and/or	erligide  ont 3 DOA  of 28c. Inju  Wo  M 1 treet, factory, office	26. Place of Deaner: 4 Nursing Hry at rk?   Yes 2 No	24a. Wa auto per 1	s an opsy ormed? 2/2 N. one) sidence how inju	o prior to death?  1 Ye  6 Other (Spaury occurred	s completion of cause of s 2 No ecity)  Rural Route Number,
	To Be Completed by	Part II. Other significant conditions of the part In Significant Condi	Hospital: 1 Inpatie  28a. Date of Injur (Month, Da)  28e. Place of Injur building, etc.	ont 2 ER/Outpatility  Year)  28b. Time Injury  At home, farm, s.  (Specify)  of my knowledge, dealexamination and/or	erligide  ont 3 DOA  of 28c. Inju  Wo  M 1 treet, factory, office	26. Place of Deaner: 4 Nursing H ry at rk?  Yes 2 No	24a. Wa auto per 1	s an posy or a corned or a corned or a corned or a corned or a corne or a cor	o prior to death?  1 Ye  6 Other (Spaury occurred	s 2 No  ecify)  Rural Route Number,  as stated, le to the cause(s)
	edical Certification; To Be Completed by	Part II. Other significant conditions of the part of t	Hospital:   Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ont 2 ER/Outpatility  Year)  28b. Time Injury  At home, farm, s.  (Specify)  of my knowledge, dealexamination and/or	ent 3 DOA Dt Wo M 1 treet, factory, office	26. Place of Deaner: 4 Nursing H ry at rk?  Yes 2 No	24a. Wa auto per 1	s an ppsy ormod? 22 No one) sidence how inju (Street a own, State and 29d. Da	o prior to death?  1 Ye  6 Other (Spaury occurred and Number or Fite)  s) and manner and place, and duate signed (Monage)	ecify)  Rural Route Number,  is stated. ie to the cause(s)
	edical Certification; To Be Completed by	Pan II. Other significant conditions of the performance of Death	Hospital:   Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ont 2 ER/Outpatile  Py Year)  28b. Time Injury  Liry - At home, farm, so.: (Specify)  of my knowledge, dealexamination and/or itted.	erligide  Lucscu  ant 3 DOA  of 28c. Inju  Wo  M 1  treet, factory, office  ath occurred at the til  nvestigation, in my of  29c. Licens  D / 5	26. Place of Deaner: 4 Nursing H ry at rk?  Yes 2 No	24a. Wan autoper 1	s an oppsy ormed? 22 N. one) sidence how injute (Street a bwn, State 29d. Da	o prior to death?  1 Ye  6 Other (Spaury occurred and Number or Fite)  s) and manner and place, and duate signed (Monage)	ecify)  Rural Route Number,  as stated.

STEPHEN KILIAN 06-01923 Unpend item#23a,27, pende, g554,4/13/06 II

State of Maryland / Department of Health and Mental Hygiene RKD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARCH 2006 8:07A. <u> 18,</u> STEPHEN WILLIAM KILIAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNAPOLIS

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1₩ 2□ F 2 JAN.15,2004 Director 213 69 9116 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f ehow other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21122 or iteme 23a 31 MARGARET ROAD UNITED STATES Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2√2 No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE 0 NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file treent of Health and Mental Hitant: If Item 27 is marked out Be 2 WILLIAM F. KILLAN AIMEE A. DENAULT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PASADENA, MD. 21122 31 MARGARET ROAD WILLIAM F. KILIAN (FATHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If eny injury or once. 03-23-06 4 ☐ Donation 5 ☐ Other (Specify) DAVIDSONVILLE, MD. LAKEMONT CEMETERY 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Fun 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Disseminated group A Streptococcal infection disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 90 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a Was an Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1

Yes 2□No 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending efter death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medicai

within 24 hours e To the Funeral C completely the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MARCH 19, 2006 O.C.M.E. 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201

State Registrar (Check only one)

LENNIE KING 06-01780 RKD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	of Maryla		artment ertificate				lental Hyg	giene Reg. No.	16	096	96
			1. Decedent's Name (First, Mid	dle, Last)								2. Date of Dea		Year	3. Time of	Death
	Physici /Medio		Lennie	Kin	ng							MARCH		2006	2:00F	, M
×.	Examir		4a. Facility Name (If not instituti	on, give s	treet and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Deat	h	
			US 301 Southbo						WBUR		04 11/20			rles		
	Funeral Director		5. Social Security Number 219–54–9479	6. Sex	M 2□F	7. Age (In yrs	s. last birthday Yrs.	/) If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da Dec. 28	v. Year)	Co	hplace (State of untry) ryland	or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. Coun	ty		10c. C	City, Town or I	_ocation							10d. Inside Ci	ity Limits
	he Maryl 28a-f ehc	Director	Maryland Anne	Aru	nde1		Harwoo		0-4-				10g. Citizen		1 Tes	2 <b>№</b> No
	a or	ä		•				10f. Zip					•			
	eeth	era	1503 E Berkl			edent Ever in	U.S. 13		2077 lent of Hi		gin? (So	ecify Yes or No			ncan Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow eimportant: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow application of the recurrent event, it a Medical Examinator must be notified at once.	by Funeral	1 Never Married 2 Mi 3 Widowed 4 XDivorce	rried	Armed F	orces? 2 □ No ive Dates: 1979		If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	Rican, etc.)	Spe	lack, White		
21215-0036	2 hou	ted	15. Deced	ent's Educ	cation		16a. Dec	edent's Usua	I Occupa	ition			16b. Kind of	Business/	îndustry	
215	within 7: ene. then "n	Completed	(Specify only high Elementary/Secondary (0-12		College (		(Giv	e kind of wor DO NOT us	k done d e retired	luring mos )	t of worki	ng				
21	giene giene	NO.	12				Sheet	Meta:	1 Me	chani	LC		Cor	struc	ction	
	el Hygid s other vent,	Be (	17. Father's Name (First, Middl	e, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Surr	ame)		
Maryland	1 Ment 1 Ment narked natic e	2	David King							Beb	oe B.	_Danie1	.s			
lar	2 sh and is m		19a. Informant's Name/Relatio	nship (Ty)	oe, Print)		19b. Mai	ling Address	(Street a	and Numbe	er or Rura	il Route Numbe	er, City or To	vn, State, 2	Zip Code)	
	and lealth m 27		David King /	<u>Fath</u>	er	200		Buffa		oad		Airy, M				
Baltimore,	t of t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □R	emoval from	State	Place of Disp cemetery, cri	ematory or of	ther place	· + P		17,	20c. Locatio	n - City or	Town, State	
ij	t. Pa tmen tant:		4 □Donation 5 □Other			Po	plar S			•	20	06			larylan	
Bal	Depending of the control of the cont		21. Signature of Fundal Service	License	to			22. Name and B E . R:			D.C.	auffer d. Mt.				
8760,	Centificate be executed the property of the purial-fransit and the purial-fransit as as the burial-fransit as the purial-fransit as	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			(or as a conse		Con	plic	ati		oy dio	um	7	Onset and I	
.O. Box 6	the death certifi y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	1 Live	utcome of pregi birth 2 ☐ Fe nant at time of nown	tal death 3	□Ectopic pre						Date of del		Year
rds, P	20 P P P P P P P P P P P P P P P P P P P	<u>م</u>	Part II. Dther significant condi	tions con	tributing to d	death but not re	esulting in the	underlying ca	ause give	on in Part I			obacco use c		o the cause of coopably 4 🗀 l	
Division of Vital Records,	elcian: The law requir s certificate has been si lirector, page 2 should I	Completed	/									24a. Was autop perio 124 Yes		prior to death?	utopsy findings completion of c	
ita	ian: intifice stor, p	Bec	25. Was case referred to media examiner?	al						26. Place	of Death	(Check only o				
5	2 2 0	10	1 XYes 2 No	Н	ospital:	Inpatient 2	☐ ER/Outpati	ent 3 DO	A Othe	er: 4□Nu	ırsing Ho	me 5 Resid	dence 6 🛣	Other (Spe	city) SCENE	Ξ
0	ng Pl		27. Manner of Death 1 □Natural 5 □ Pend	fina	28a. Date (Mor	of Injury oth, Day Year)	28b. Time Injury	of 2	8c. Injury Work	at		28d. Describe to	now injury och	urred of	rencle no	ollision
Sio	endi eath. or: A the fu	Certification:	2 Accident inve	tigation	3-1:	2-06	13:2	7PM	1 🗆 '	res 2 🔀	No	off hind	ge inte	rive	w.	
Ξ	or Att	Ě		mined	28e. Plac build	e of Injury - At ling, etc. (Spec	home, farm, s cify)	street, factory	, office			28f. Location (S City or Tov	Street and Nu vn, State)	mber or Ru	ral Route Num	uM I.
Q	rs ef					high	No. of Lot	bon da	بع			@ Harr	y Nice	Bno	ige	
	To the Hospital or Attending Phymith 24 hours effer death. To the Funeral Director: Affer it completely filled in by the funeral.	edicai	29a. Certifier 1 Certify (Check only 2 Madic	ring Phys al Examir	er: On the I	basis of examin	nowledge, dea nation and/or	ath occurred a investigation,	at the tim in my or	ie, date an pinion, dea	nd place, oth occurr	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	s stated. to the cause(s	s)
	the thin 2 the mple	Med	29b. Signature and title of centr	ier	A and mar	nner stated.		290	License	number			29d. Date sig	ned (Mont	h Day Year)	
	₹ <u>₹ ₹ 8</u>		X	16	Lun			250								
	HILL		7710	V		10	\	04-0	0.0	M.E.		M	ARCH 1	J, ZU		
//	His.		30. Name and address of person	40	GA	P _			PENN	STRE	ET B	ALTIMOR	E, MAR	YLAND	21201	
	Sta Registi	_	31. Date filed (Month, Day, Yea	162		Registrar's Sign		Speeds	,							

			State of Maryland / Department of Health and N  1 - State Registrar Certificate of Death		ene 2.000 (	09694
	Dhysiei		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Dorothy Albertia Kline	March 1	2,2006	9:15P M
1	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6550 Cardinal Drive 1.a Plata		4c. County of Death	
	E		6550 Cardinal Drive La Plata  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Char 9. Birth	Les place (State or Foreign intry)
	Funeral Director		Months Days Hours Min.	Month, Day, You ember 3	.1944 Wa	shingtonD(
	pu >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	faryla shov	ō				1 ☐ Yes 2121 No
	the N	Funeral Director	MD Charles La Plata  10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	intry?
	3a or		6550 Cardinal Drive 20646		USA	
	death	ner	12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Amer Black, White	
36	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show	by Fu	1 Never Married 2X Married 1 Never Married 2 No Specify:	,		White
21215-0036	hour tural	ed b	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	16	ib. Kind of Business/li	
15	c * 39	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life, DO NOT use retired)			,
212	d within giene. er than ", Ire Ma.	mo	12 Homemaker		Hom	e
nd	be filed stal Hygir of other event, I	Be		e (First, Middle, Ma		
yla	should be nd Mental marked o	ဥ			tia King	in Code)
Maryland	d 2 sho	6 1	19a. Informant's Name/Relationship (Type, Print)  Richard Kline/Husband  19b. Mailing Address (Street and Number or Rur  6550 Cardinal Dr.		•	
	is 1 and 2 should be filled of Health and Mental Hyg item 27 Is marked othe other treumatic event,				c. Location - City or T	
mo	0 0		1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Resurrection Cem. 3/16	706 CT	inton Ma	rvland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee M00945 22. Name and Address of Facility AREHART - ECHOLS			
	_		P.O. BOX 567 LA  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	PLATA . ] or respiratory arrest	MD 20646	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final LUPE CAP CER			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate auto. Ent. Indian frig. Cause (Disease or injury		5	
	be executed sician and burial-transit	xan	that initiated events c			
8760,	e be e siciar s buria		d			
9	tificate ig phys as the	ledio			/	
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delin	very Day Year
	it the dea by the ati tached fo	sici	in the past 12 months?  1   Yes 2   No 9   Unknown	<del></del>	NOTH	Day Foal
P.0	that th		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	uires l signé	d by		1 ☐ Yes	2 □No SEPro	bably 4 Unknown
cor	w requ	Completed		24a. Was an	24b. Were aut	opsy findings available
Re	9 4 9	дшо		autopsy performe 1 ☐ Yes 2	prior to c death?	ompletion of cause of 2 ☐ No
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Deat	th (Check only one)	- 100	20110
of V	ysici is ce direc	To B	examiner?  1   Yes   2   FR/Outpatient 3   DOA   Other: 4   Nursing Ho	ome siden	ce 6 □Other (Spec	ify)
		ii o	27. Magner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury Work?	28d. Describe how	injury occurred	
isio	ten leat lor: the	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or Ru	ral Route Number
Division	of or Attence after death I Director:	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  Check only one)	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier  29c. License number	29d	J. Date signed (Month	, Day, Year)
0			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Krish	nan Mathi	ır,M.D.
	NB3		PO Box 1703 LoPlata 1	ND	2064	6
102	Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 5 2006  32. Pigistrar's Signature			
			Polymer and the second			

				ype or Print in BI State of Maryland				-	•	le.	0.005
			1 - For State Registrar	State of Warytand		tificate of			g, No.	U	4640
	Physici	an.	1. Decedent's Name (First, Middle, Last)	_				2. Date of Death Month March			3. Time of Death
	/Medic	cal	James David I  4a. Facility Name (If not institution, give s			4h City Town	or Location of Death		4c. County of		3:40 Pm
	Examin	er	3922 Church Ro	ad		Mil	lers		Balt	imor	
	Funeral Director		5. Social Security Number 6. Sex 220-62-1647	7. Age (In yrs. la: M 2□F 44	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Jan. 28,	1962	9. Birthplac Country, Mary.	e (State or Foreign land
	Maryland a-f show	ctor	Usuel Residence of Decedent  10a. State 10b. County  MD Baltimo	**	Town or Lor iller					10d.	Inside City Limits
	3a or 28	I Director	10e. Street and Number 3922 Church R	oad		10f. Zip Code 211	02	10	g. Citizen of Wh ${\sf U}$ . ${\sf S}$ . ${\sf A}$ .	-	?
020	urs after deat al', or Items 2 Examiner mu	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Moroced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American White, etc Whi	
0-61212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Menall Hygiene.  Misportant: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 90Ge.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. L	ent's Usual Occu kind of work done OO NOT use retire Denter	pation during most of wor ed)	king	6b. Kind of Busi Self F		
/and	uld be file Mental Hyg Irked othe Itic event,	To Be C	17. Father's Name (First, Middle, Last) James David La	wson, Sr.				ne (First, Middle, M R. Ruhl	aiden Surname,	)	
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship (Type James D. Lawso					ral Route Number, Freela			
aitimore,	Pages 1 a nent of Hez int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	TYK E'Ö	sition (Name of natory or other pla WNE ON Serv	ice 200	ch 22.	oc. Location - C		
Dail	permit. Departn Imports any inju		21. Signature of Funeral Service License	Munano				J. Harte New Fre			
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Finel disease or condition resulting in death)	eations that caused the death. e cause on each line.  Cunshotu  Due to (or as a conseque	bun	1 - 1	1	or respiratory arre	st,	O	pproximate terval Between nset and Death
/ '00	be executed cian and burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Each thoday Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
9	that the death certificate be ex ed by the attending physician of detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnan 1	death 3□	Ectopic pregnand Other (specify) _	ey .		23d. Date Monti	-	ay Year
	Se G	δ	Part II. Other significant conditions con	tributing to death but not result	ting in the ur	nderlying cause gi	ven in Part I.		acco use contrib	oute to the d	
ř	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	ed? de	ath?	findings available letion of cause of
N I G	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Ot	han	th (Check only one			
ō	Phys this raldi	. To	27. Manner of Death	1   Inpatient 2   E	28b. Time of	28c. Inju	iry at	28d. Describe how	nce 6 Other vinjury occurred		
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Nanch 21, 2006 (28e. Place of Injury - At hombuilding, etc. (Specify)	540 F	M 10	ork? ]Yes 2 XNo	28f. Location (Stre City or Town,	eet and Nimber State) 392	or Rural R 2 Chu	To head
5	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Phys	icien: To the best of my know	HOII ledge, death	le occurred at the t	ime, date and place	Mil.	lers,	MD 2	1102 ed.
	the Hin 24 the Fi	Medical	one)	er: On the basis of examination and manner stated.							
)	T with		29b. Signature and title of certifier	D D = L.		1 10	se number \$667		d. Date signed (		
	15		30. Name and address of person who con	_ 11	23a) (Type,			le MD			
e	Sta Registr		31. Date filed (Month, Day, Year) 200	6 32 Registrar's Signatu	-	affet	-41-10101		0.0	·)	

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	•	For State Registrar	State of I	Maryland /		tment of I <i>ficate of</i>		ınd Me	_	iene eg. No.	()(5	096	96
Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month March 1		Year	3. Time of	
/Medic		Maria A. Liriano		1		Ch. Town	- Location o		March 1	1	nty of Death	4:43	p h
Examin	er	4a. Facility Name (If not institution, give s Washington Advent:			4	1b. City, Town, o	a Park			40.000		tgomery	7
/E		5. Social Security Number 6. Sex		Age (In yrs. last b		If Under 1 Year	If Under 2		B. Date of Birth (Month, Day	1	9. Birth	place (State	
Funeral Director			M 2√2 F		2 Yrs.	Months Days	Hours	Min.	ug. 6,	1923		<sup>intry)</sup> Lcan Rep	ublic
D.		Usual Residence of Decedent										104 1	in a literal
anylar show	_	10a. State 10b. County		10c. City, To								10d. Inside C 1 ☐ Yes	
filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show thet, the Medital Examinar must be notified at	Directo	Maryland Prince Ge	eorge's		Hyatt	sville 10f. Zip Code				IOs Citizon	of What Cou		
with t		10e. Street and Number 2006 Lewisdale D:	rive			20783				rog. Oliizeri	USA	and y:	
eath	erai		12. Was Decede	ent Ever in U.S.	13. Wa	s Decedent of I	Hispanic Orig	gin? (Spec	ify Yes or No-	14.1	Race - Amer	ican Indian,	
r Iter o	Funeral	1 Never Married 2 Married	Armed Force	es? <b>:K</b> ∏No	If Y	es, specify Cub	an, Mexican	i, Puerto R	ican, etc.)		Black, White		
al', o	by	3 ☐Widowed 4 🛣Divorced	If Yes, Give Year or Date	es:	1.5	Yes 2□ No	Specify:	Мини	Call	Spe	ecify: WIII		
72 nc natul	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16	(Give kir	nt's Usual Occu nd of work done	during most	t of working	9	16b. Kind o	f Business/I	ndustry	
Affirm Par Par Par Par Par Par Par Par Par Par	пр	Elementary/Secondary (0-12)	College (1-4	or 5+)	Bus G	NOT use retire	ed)			Moak	d = ~ t = 1	n Hilto	
ther t	ပိ	17. Father's Name (First, Middle, Last)			Dus G		18. Mothe	er's Name (	(First, Middle,			1 HIIC	J11
ed of	Be	Antonio Liriano					Enr	rique	ta Liri	ano			
mark mark	၉	19a. Informant's Name/Relationship (Typ	pe, Print)	19	b. Mailing	Address (Stree	t and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Z	ip Code)	-
27 Is a C		Teresita Gonzalez	/Daught	er 6	408 J	odie St	reet,	New 0	Carroll	ton,	MD 20	784	
E E ED		20a. Method of Disposition		cemet	of Disposit	ion (Name of tory or other pla	ice)	Da Marcl		20c. Locati	on - City or T	Town, State	
nt: H	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from St	ate	-	iven Cemet		200		Silver	Sprin	ng, Mai	cy1
penint. Tages ratio About Hygiene. Important: if item 27 is marked other then "natural, or Items 23s or 28s-f show eny Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	Cole			Mame and Addr Mc18 July Univer						g, MD 2	209
*		23a. Part1. Enter the disease, or o pli shock, or heart failure. List on on	ications that cau	used the death. De	o not enter	the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approxima Interval Be	tween
nysician		Immediate Cause (Final disease or condition		iogenic :	Shock							Onset and	Death
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and al-tran	Examiner	that initiated events resulting in death) Last	D	nary Arte		Isease							
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eath certifical attending place as the forms of the second	Physician/Me	23b. was decedent pregnant		ome of pregnancy th 2 Detail dea	th 3∏E	ctopic pregnanc	·v			23d.	Date of deli	*	V
5 ± 5	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death		Other (specify)	.,				Month	Day	Year
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ystrain. The law requires was the sis certificate has been signed by the director, page 2 should be detache	To Be Completed by	Acute Renal Failu:  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be	re, Acu	patient 2 ER/( Injury Day Year)  28b	Outpatient D. Time of Injury	y Distr	26 Place ther: 4 Nu iny at ork?	of Death ursing Hom	24a. Was autop performed in Yes (Check only of the South Park only of the South Park on South Park o	an sy rmed? 2 No ne) dence 6 one injury of	4b. Were au prior to death? 1 Yes Other (Spec	topsy findings completion of 2 \( \text{No} \)	
ysician: The law requires that the is certificate has been signed by the director, page 2 should be detache	To Be Completed by	Acute Renal Failu:  25. Was case referred to medical examiner? 1  Yes 2  No  27. Manner of Death 1  Acudent investigation 3  Suicide 6  Could not be	re, Acu	te Respi	Outpatient D. Time of Injury	y Distr	26 Place ther: 4 Nu iny at ork?	of Death ursing Hom	24a. Was autop performed to the control of the cont	an sy rmed? 2 No ne) dence 6 one injury of	4b. Were au prior to death? 1 Yes Other (Spec	topsy findings completion of 2 \( \text{No} \)	
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or Attending Physician: The law requires that the Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	edical Certification; To Be Completed by	Acute Renal Failu:  25. Was case referred to medical examiner?  1   Yes   2   Yes    27. Manner of Death   Yes   2   Accident   Investigation    3   Suicide   6   Could not be   determined    29a. Certifier   (Check only one)   2   Medical Exami	re, Acu  lospital: 1 25 In 28a. Date of (Month) 28e. Place of building	patient 2 ER/	Outpatient D. Time of Injury  farm, street	y Distr  3 DOA 28c. Inju W M 1[ at, factory, office	26. Place ther. 4 Numy at ork?  Yes 2	rndroll a of Death ursing Hom No 2	24a. Was autop purposed to the control of the contr	an sy sy med? 2 No ne) dence 6 Downinjury or win, State)	4b. Were au prior to codeath? 1 Yes Other (Specicured	topsy findings completion of 2 No 2 No cify)	mber,
dospital of Attending Prystcian: The law requires that the A hours after death: -tuneral Director: After this certificate has been signed by the funeral director, page 2 should be detached.	edical Certification; To Be Completed by	Acute Renal Failu:  25. Was case referred to medical examiner?  1   Yes   2   Yes    27. Manner of Death   Yes   2   Accident   Investigation    3   Suicide   6   Could not be   determined    29a. Certifier   (Check only one)   2   Medical Exami	Hospital: 1 Min 28a. Date of (Month 28e. Place of building sician: To the biner: On the bas and manner ompleted cause	patient 2 ER/ Injury 28t  of Injury - At home, g, etc. (Specify)  post of my knowled bis of examination ar stated.	Outpatient D. Time of Injury  farm, streed and/or inve	y Distr  3 DOA 28c. Inju W 10  at, factory, office occurred at the stigation, in my 29c. Licer	26. Place ther. 4 Numy at ork?  Yes 2	ndroi e of Death ursing Hom 2 l	24a. Was autop purposed to the control of the contr	an sy med? 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	4b. Were au prior to c death? 1 Yes  Other (Special Courred)  d manner as ice, and due	topsy findings completion of 2 No 2 No cify)  stated. to the cause( h. Day, Year)	nber.

			For State	State	of Marylar		artment of H		Mental H	6.	UUU		19697
			Registrar  1. Decedent's Name (First, Middle	, Last)		007	inicate or i	Jean	2. Date of	Rag. No Death		-	3. Time of Death
	Physici		D	D4-1			T -		Month	Day		ar	7 054 M
	/Medic Examin		4a. Facility Name (If not institution	Dinh , give street and nu	ımber)		4b. City, Town, or	Location of Dea	March		2006 County of E	Death	7:05A
			20912 Severnda	le Terrac	e		Germant	OWD			Montgo	omer	v
	Funeral		5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9.		ice (State or Foreign
	Director		216 96 3900 Usual Residence of Decedent	10.141 201	46	Yrs.			Dec.	12, 1	959 V	Viet	Nam
	land land		10a. State 10b. County		10c. C	ity, Town or Lo	cation					100	d. Inside City Limits
	Mary 1 sh	ţ	W11 W		C								1 ☐ Yes 2 🛣 No
	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f ehow ha Medical Exertine mast be notified at	Director	Maryland   Montg	ошегу	- Ut	ermanto	10f. Zip Code			10g. Cit	izen of Wha	t Countr	ry?
	th witi	ai	20912 Severndal	e Terrace	2		208	376			US	SA	
	dea .	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or	No-	14. Race - A Black, V		
9	or it	by Fu	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, G	2 <del>∐T</del> No ive		1 ☐ Yes 2☐No	Specify:			Specify:		
215-0036	tural'		3 ☐ Widowed ♣☑Divorced	Year or I	Dates:		dent's Usual Occup	ation		16h K	ind of Busin		
Ċ	in 72 n" r	olete	(Specify only highes	t grade completed,		(Give	kind of work done of NOT use retired	during most of wo	orking	10b. K	ing of Busin	ess/muu	istry
212	d with jiene. r tha	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Engineer			SET	A Cor	oora	tion
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or itema 23a or 28a-f show event, the Medical Exercitrat relative notified at	BeC	17. Father's Name (First, Middle,	Last)			- iiktii	18. Mother's Na	me (First, Mide				
<u>a</u>	should b nd Ments marked umatic e	ToE	Unknown					Muoi P	si Nguy	en			
Maryland	es 1 and 2 should be of Health and Mental I fram 27 is marked or other traumatic even		19a. Informant's Name/Relations	nip (Type, Print)			ng Address (Street						
	and lealth m 27 her tr		Thuy X. Pham /	POA	1005	and the second		le Terra		-			and 20876
Baltimore,	Pages 1 Int: If ital	ll i	20a. Method of Disposition 1    Burial 2 □ Cremation	3 □Removal from		cemetery, crer	sition (Name of matory or other plac	1	Date	20c. Lo	ocation - City	or low	in, State
	t. Pa		4 Donation 5 Other (S)		Par		Mem Park		4/2006			_	laryland
Ba	permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service	Le	war		2. Name and Address 800 New H						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	th. Do not ent	er the mode of dyin	g, such as cardia	c or respirator	y arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hen	otoce11	ular Ca	arcinoma						Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	22.0.2.110,002						
	ZAGIIIII	er	Sequentially list conditions, I any, leading to intro-eclats cause. Enter Underlying	b. —	(or as a gonse	reserves offi							
	nsit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events										
<u>,</u>	exection and ial-tra	Examin	resulting in death) Last	Due to	(or as a conse	quence of):							
8760	icate be executed physician and s the burial-transit	dicai		d									
9	ntifica ng ph as th	Aed	IF FEMALE:							-			
Box	The law requires that the death certificate hes been signed by the attending I agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pregribinth 2 Fet		Ectopic pregnancy				23d. Date of Month		y Day Year
	e dea the at hed fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Preg 9☐ Unkr	nant at time of	death 5	Other (specify)			-	MONUT		оау төаг
0.	that the de sed by the a detached t		Part II. Other significant condition	MS contribution to	death but not re	sulting in the u	nderlying cause give	en in Part I	23e D	id tobacco i	use contribu	te to the	cause of death?
Records,	uires tha signed d be de	d by			3-2 2-4040	outig iii iiio u	indonying debug giv	J					bly 4 □Unknown
Ö	w require been sig should t	ete							24a. W	fac an	24h Wer	e autoni	sy findings available
ğ	The lav	Completed							au	itopsy erformed? s 2⊟No	prior	to com	pletion of cause of
Vital		C	25. Was case referred to medical					26. Place of De			1 🗆	Yes 2	№ No
	W ==	0 0	examiner? 1 ☐ Yes 2 <del>☑ N</del> o	Hospital:	Inpatient 2	BR/Outpatier	nt 3 DOA Oth		Home 5 R		6 ∏Other (	Specify)	
to	ding Phy h After this funeral c	in:	27. Manner of Death	28a. Date		28b. Time of		y at	28d. Descrit				
ŏ	ath er: Af	atic	1 ▼ Natural 5 □ Pendin 2 □ Accident investig	pation	,,,	,,		Yes 2 □ No					
Division	i or Attend after death Director: / J in by tile f	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Plac	e of Injury - At I ding, etc. (Spec		eet, factory, office			n (Street ar Town, State		r Rural	Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fame	Medical C	(Check only 2 Medical	g Physician: To th Examiner: On the	basis of examin	lowledge, deatl	h occurred at the tin vestigation, in my o	ne, date and place	e, and due to t	he cause(s	) and manne d place, and	er as sta	ted. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier		nner stated.		29c. License	e number		29d. Da	te signed (N	fonth, D	ay, Year)
	20		Par & Barre	1			MAG	60335		Ma	rel	13	2006
			30. Name and address of person	who completed cau	ise of death (Ite	m 23a) (Type,	Deigas			1 10	^	+	
			Paul Bannen	18111	rince f	Kilip 1	Driva # 3	27 0	lney,	MO	2083	2	
	Sta Registr		31. Date filed (Month, Day, Year)	4 2006 4	Hegistrar's Sign	nature .	parte		/				
-54	ricgisti	uı	111111 I										

				ate of Marylar				-		
			1 - For State Ragistrar	ate of warytar		tificate of i			leg/No.D D 6	09698
-	*	8° ,	Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Media		Roy Lee Lewis					March	Day Year	6 9:57 PM
	Examir		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	r Location of	Death	4c. County of Dea	th
		á.	Washington County Ho	spital		Н	agerst		Washing	ton County
£ 80	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	Hours	Min. (Month, Day	Year) 9. Bir	thplace (State or Foreign ountry)
,	Director		Usual Residence of Decedent	6.	3			April 2	2 1942   Mai	ryland
	yland		10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits
	B Mar	ctor	PA Frankli	n Wa	aynesbo	oro				1 Yes 2 □ No
	है कि कि 80 28	Director	10e. Street and Number			10f. Zip Code		1	l 0g. Citizen of What C	ountry? -
	ath w		282 West Second S		- 1	17268			U.S.	
	lte de	Funeral	A	Vas Decedent Ever in U Impd Forces? ☑Yes 2☐No	.S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whi	
36	urs aff	by F		Yes, Give 'ear or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: V	White
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or tema 23a or 28s-f show event, it a Medical Examinar must be muitted at		15. Decedent's Educatio		16a. Deced	lent's Usual Occup	ation		16b. Kind of Business	/Industry
215	thin 7	Completed	(Specify only highest grade cor Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life. I	kind of work done of OO NOT use retired	d) most d	or working		
2	filed wi Hygien other th	Co	12		Inte	ercity Ma			City Gove	ernment
ng	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle,	Maiden Sumame)	
<u>2</u>	should be and Mental s marked o umatic eve	70	Gaither Lee Lewis	Delant	105 14-25-	- Add /C4A		len Louise		7-0-4-1
Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumatic as ODCs.		19a. Informant's Name/Relationship (Type, F			-		or Rural Route Number	1000	
	Heali Heali tem 2 other		Lori E. Miller (daug	20b. F	Place of Dispo	sition (Name of		d Waynesbor	20c. Location - City or	Vania 17268 Town, State
JOH L	ages ant of tt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State We	elty Ch	natory or other place urch of	ce)	3-21-06	Smithsburg	bnelvreM
Baltimore,	in Indian		21. Signature of Funeral Service Licensee	th the	ne Bret	hrcn Name and Addres	ss of Facility			-
m	Per		/ )uncla A	Xing				Douglas A. d. N. Hager	Fiery Fur	
	2	1	23a. Part1. Enter the Hease, or complication shock, or heart inclure. List only one ca	ns that caused the deat	h. Do not ent	er the mode of dyin	ig, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	Sant is	56	ock on	nd	7, nazu	-	Onset and Death
1	/Medical		resulting in death)	Due to or as a conseq	uence of):	1	100	Fungem		a y ca
	Examiner		Sequentially list conditions, b	NECLOTIC	150	wel		11,87,1		
	Da ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	1	Absc				
	be executed icien and burial-transit	хап	that initiated events c/	Due to (or as a conseq	uence of):	1713 SC	e 55			
9	be executed sicien and burial-transit	calE								
687	¥ × 8		d							
	anding use a	n/M		yes, outcome of pregna		I.			23d. Date of de	livery
.O. Box	death e atte	icla	1 Vec 2 No	Live birth 2 Feta		Ectopic pregnancy Other (specify)			Month	Day Year
о. О	at the by th	hys	9 Unknown	Unknown						
	The law requires that the death certifica ate has been signed by the atlending ph bage 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions contribu	11		0			bacco use contribute to	
ord	sen s	ted	Hime respirary	y distre	5554	ndrame	1	7		robably 4 [Unknown
Records,	taw las b	nple	Aute renal to	ilure	regu	iring	dia	autops	SV Drior to	utopsy findings available completion of cause of
_			Dysphagia d	ue to n	usel	- wear	nes:	1 ☐ Yes	med? death? 2 No 1 ☐ Yes	2 □ No
Vital	Attending Physician: The law r death. sctor: Aller this certilicate has k by the funeral director, page 2 s	Be	25. Was case referred to/medicat examiner?	lal:		Othe		f Death (Check only or		
	Phys r this ral di	5	1 195 258110	a. Date of Injury	ER/Outpation 28b. Time of	t 3 DOA	4 ☐ Nurs	ing Home 5 Reside	ence 6 □Other (Spe ow injury occurred	icify)
Division of	ding th. : Atte	ţ	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	28c. Injun Work	k? Yes 2∐No		,,	
N N	Atter octor by the	ifice	3 Suiside 6 Could not be	e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S	treet and Number or R	ural Route Number,
۵	Hospital or Attending Physical hours after death.     Funeral Diractor: After this etely filled in by the funeral director.	Certification;	4   Homicide	building, etc. (Specit	<b>y</b> )			City or Town	n, State)	
	lospi hour uner		29a. Certifier 1 Certifying Physicial 2 Medical Examiner:	n: To the best of my kno	wledge, death	occurred at the tim	ne, date and	place, and due to the c	ause(s) and manner a	s stated.
	To the Hospitel or Attending Ph wibin 24 hours after death. To the Funeral Director: Alter th completely filled in by the funeral	Medical	oney	and manner stated.						
	Viil To Cor	-	29b. Signature and title of certifier	(1)		29c. License		- 2	9d. Date signed (Mon	h, Day, Year)
			· way c wine	a) W)			013		3-17-	06
61	1-10+1		30. Name and address of person who comple	ted cause of death (Item	g 23a) (Type,	10 can	int	72178	0.	
T	Sta	te	31. Date filed (Month, Day, Year)	32. Begistrar's Signa	nture /	Town,				
	Registr	_	MAR 17 2006	Buren 1	3. pp	cike				
				7						

			For State Registrar	State	of Mar	yland /		rtmen tificate		ealth and N Death	Mental Hy	/giene Reg. No.	006	090	99
			Decedent's Name (First, Middle	e, Last)							2. Date of D	eath Day	Year	3. Time o	f Death
	Physicia		E. Kennedy Lang	staff							March	11,	2006	5:00	РМ
	/Medic		4a. Facility Name (If not institution		umber)			4b. City,	Town, or	Location of Death	)	4c. C	ounty of Dea	th	
			Buckingham Choi	ce				Ada	msto	wn		Fı	rederi	ck	
	uneral		5. Social Security Number	6. Sex		(In yrs. last		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	au Vaari		thplace (State	or Foreign
E	irector		132-16-4624	1 <b>∑</b> M 2 ☐ F	3	83	Yrs.				Feb. 1		New	York	
pur	*		Usual Residence of Decedent  10a, State 10b, County		1	10c. City, T	own or Loc	cation						10d. Inside C	ity Limits
Aaryl	o a b	ō	CT Fai	rfield		Stam	ford							1 <mark>%</mark> Yes	2 🗌 No
the A	28a-	rect	10e. Street and Number					10f. Zip	Code	<del></del>		10g. Citize	n of What C	ountry?	
death with the Maryland	Sa or	Funeral Director	307 Ingleside	Road				0	6903			unite	d Sta	tes	
death	TIB 2	era	11. Marital Status	12. Was De		rer in U.S.	13. V			spanic Origin? (S n, Mexican, Puen	pecify Yes or N	lo- 14		erican Indian,	
uffer	or item	교	1 ☐ Never Married 2 🔀 Marr	ied 1 X Yes	2 No	)		Yes, spec			o Hican, etc.)		Black, Whi	te, etc. Vhite	
Hours &	Entr	ð	3 Widowed 4 Divorced	If Yes, G Year or				⊔ Yes	2E3 NO	Specify:		3	pecify:	MILLE	
2 P	natu	Completed	15. Deceden (Specify only higher	t's Education st grade completed	1)	1	6a. Deced	kind of wo	rk done a	uring most of wor	king	16b. Kind	of Business	/Industry	
it i		mpi	Elementary/Secondary (0-12)		(1-4or 5+)	) E.	ا ۱۴۵۰ xecut	OO NOT u	se retired, Seai			Cons	ulting	g Firm	
A P	her t		17. Father's Name (First, Middle,			Б.	xecut	.1 / E	bear	18. Mother's Nan	ne (First Midd			5 111111	
d be file	ed of	Be	Bridgewater Mer		osta	ff				Esther 1					
Noul C	d Me nark natio	ဥ	19a. Informant's Name/Relations		.60 04.		19h Mailin	a Address	/Street a	and Number or Ru				Zip Code)	
d 2 st	Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturst", or items 23a or 28a-f show supportent: if item 27 is marked other then 20an in a part injury or other treumatic event, it in Medical Examinat must be notified at another.  200ce.	P	Lee Langstaff /					•	•	ired Rd,					
a, - g	Heal Ism 2		20a. Method of Disposition	Daugneer	-	20b. Place	e of Dispo	sition (Nar	ne of	-	Date			Town, State	
	t: If if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State		<sub>etery, cren</sub> erick	-		·	/2006	Frede	rick.	Mary1a	nd
SAITIMOI Dermit. Peges	ortsn injur		21, Signature of Funeral Service							s of Facility St					
<b>D</b> §	en year		Broller 1							ımtown P					
-			23a. Part1. Enter the disease, or shock, or hear failure. List	omplications that	t caused th	he death. [	Do not ente	er the mod	le ol dying	g, such as cardiad	or respiratory	arrest,		Approxima Interval Be	ite tween
Dh	ysician	- 1	Immediate Cause (Final			c Car								Onset and	Death
	Medical		disease or condition resulting in death)	a		consequen								2 mon	T715
Ex	aminer		Commentation line and distance	h .											
	=	Je.	Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a	consequen	ice of):								
cuted	ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
<b>bU,</b> be executed	been signed by the ettending physicien and should be delached for use as the burlat-transit	Ä	resulting in death) Last	Due	o (or as a	consequen	ice of):								
8/6U	physic the b	dicai		d.										1	
. BOX 68/ death certificate	ding p	0	IF FEMALE:	23c. If yes, c	outcome of	f oregnancy	v					22	ld. Date of de	linger	
<b>BOX</b>	ettend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal de	ath 3	Ectopic p				23	Month	Day	Year
غ جَ ق	the	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□Unle		ino or deat	5	200101 (3)							
r a	ed by deta	F.	Part II. Other significant conditi	ons contributing to	death but	not resultir	ng in the u	nderlying o	ause give	en in Part I.	23e. Did	tobacco us	e contribute	to the cause of	death?
OrdS, P	n sign	Completed by	Parkinson's	Disea	se						10	Yes 2	No 3□F	robably 4	JUnknown
	shou	lete									24a. Wt		24b. Were a	utopsy findings	available
The law	certificete hes rector, page 2	шс									aut per 1 ☐ Yes	opsy formed?	death?	completion of s 2 □ No	cause of
	ifficet or, pa	ပိ	25. Was case referred to medica							26. Place of Dea			10.78	2 2 140	
Sici S	is certific director,	To B	examiner? 1 ☐ Yes 2 ⊠ No	Hospital:	] Inpatient	t 2 ER	VOutpatien	it 3□ D0	Othe	20	iome 5 ☐ Re		☐Other (Sp	ecify)	
9 P. y.	th. : After this : funeral o		27. Manner of Death	/4.4.	e of Injury	Year) 28	Bb. Time of Injury	1	28c. Injury Work	at	28d. Describ	e how injury	occurred		
<b>O</b> F	tor: Afr the fur	atic	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	gation	, , , , , ,			М		Yes 2 ☐ No					
DIVISION I or Attending	irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pla	ce of Injur Iding, etc.	ry - At home (Specify)	ə, farm, str	eet, factor	y, office		28f. Location City or 7	(Street and own, State)	Number or F	Rural Route Nu	mber,
<u>ة</u>	ours aftenerication of the properties of the pro														
Hosp	within 24 hours after death.  To the Funerel Director: After this certifice completely filled in by the funeral director,	Medical		ng Physicien: To t Exeminer: On the	basis of e	examination									s)
the c	within 2 To the comple	Med	29b. Signature and title of certifie		anner state	ea.		29	c. License	e number		29d. Date	signed (Mor	nth, Day, Year)	
ř	3 F 8		Dail.								7		-15-		
١	5		30. Name and address of person		M O	ath (Itam 2)	3a) (Tune	Print)		00587					
1				Medical	Gran	0	2030	oes ⊶ T	> V-	entrie (	3+, MV	ersu!	le mo	2177	3
	Sta	ate	31. Date filed (Month, Day, Year	G 2006 32	Cojstrar	s Signatur	K /	bout	1	entrie (					
	Regist		WAK T	0 2000	1		- 17	-							

AEM 06-01812 Bruce C. Looney

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

e (	J. LOO	ney	۷ 1	For State Registrar	State of Ma	ryland / [		artment of H				006	09700
				Decedent's Name (First, Middle,	Last)			timodio or i		2. Date of De			3. Time of Death
	Physic			Bruce Clyde L	oonev					March	$13,^{Day}$	2006 Year	7:17 P M
	/Med Exam			la. Facility Name (If not institution,				4b. City, Town, or	Location of Death	1	4c.	County of Death	
				12514 Kavanaugl	n Lane			Bowie			Pr	cince Ge	orge's
	Funera	ı			6. Sex 7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	av. Year)	9. Birth	place (State or Foreign ntry)
	Directo	r	-	214-82-6156 Usual Residence of Decedent	Z W Z L	46	Yrs.			Sept 1	1, 19	)59 Wa	sh. D.C.
	land		-	10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Mary -f eh	ģ	, <sub>,</sub>	Maryland Prince	George's	Bowie							1 XYes 2 No
	r 28a	Director	3	10e. Street and Number	occige b	20 11 20		10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	th with	a D		12514 Kavanaugh	Lane			20715			USA		
	ame arm	Funeral		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No o Rican, etc.)	o- 1	14. Race - Ameri Black, White,	
36	or it	by Fi		Never Married 2 ☐ Marrie  3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	0		1 ☐ Yes 2 🗓 No	Specify:			Specify: TTL =	+ 0
8	72 hours after death with the Maryland natural; or itame 23a or 28a-f show dieal Examinar must be nutified at			15. Decedent's	Year or Dates:	16a	Dece	dent's Usual Occupa	ation		16h Kir	Whi	
5	in 72 n "na	Completed		(Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	luring most of wor )	king	100.11		
212	e filed within al Hygiene.	E		Elementary/Secondary (0-12)	College (1-4or 5-		ect:	rician			Cons	structio	n
b	be filed within 72 hours after death with the Marylan tiel Hygiene. Id other than "natural", or itame 23a or 28a-f ehow event, the Medical Examinar must be notified at	BeC	3	17. Father's Name (First, Middle, L					18. Mother's Nan		, Maiden :	Sumame)	
<u>a</u>	should be nd Mentel I marked o	10		Bobby Clayton Lo	oney				Etta Lee	Payne			
Maryland 21215-0036	Pages 1 and 2 should be ment of Heelth and Mente ant: If Item 27 is marked iury or other traumatice	1	- 1	19a. Informant's Name/Relationsh Brian C. Looney/				ng Address <i>(Street a</i> Pirch Way				Town, State, Zi	p Code)
	1 and Heelt em 2	1	-	20a. Method of Disposition	22001101			sition (Name of matory or other place		rch 16,		cation - City or T	own, State
Baltimore,	ages int of it: if it y or o			1 ☐ Burial 2 [XCremation 4 ☐ Donation 5 ☐ Other (Sp				natory or other plac ke Cremat	-	006			Maryland
Ħ	permit. Page Depertment of Important: If any injury or	4		21. Signature of Funeral Service L		onesa	_	2. Name and Address Ding Home					
ä	permit. Depertrimports			Being t	Helito	- MO125	1 B	oing nome everly L.	Heckrot	te. P.A	. Cla	r.o. bo rksvill	e, MD 21029
				23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each lin	the death. Do							Approximate Interval Between
	Physician	1		Immediate Cause (Final disease or condition	TO	tran	60	1 Gun	ELat L	Lours	Q		Onset and Death
1	/Medica Examine			resulting in death)	Due to (or as a	consequence	of):		37-0				
п	LXamme	ě		Sequentially list conditions,	b	. consequence	P		-				
	ted nsit	nine		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 15 (6) 43 8	Consequence	01).						
Ţ,	execunand nand ial-tra	Examin		that initiated events resulting in death) Last	C. Due to (or as a	1 consequence	of):						
8760,	cate be executed physicien and the burial-transit	dicai	3		d.								
9		- Q	) -	IE ECNAMI E.									
Вох	eath certific attending p	an/	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 □ Live birth		3 [	Ectopic pregnancy			2	3d. Date of deliv	very Day Year
о. П	at the dea by the at tached fo	Physician/M	2	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 1 9 ☐ Unknown	time of death	5	Other (specify)				WOIT	Day Tour
<u>α</u>	that the			Part II. Other significant condition	 ns contributing to death bu	ıt not resultina i	n the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Records,	sign d be	P P						, , ,		10	Yes 2	No 3□Pro	bably 4 Unknown
S	3 11 0	Completed								24a. Was	an		opsy findings available
Re	The la ete has page 2	Ĕ								auto perf Yes	ormed? 2 ☐ No	prior to co	ompletion of cause of 2 No
Vital	an: rtifice tor, p	0	)	25. Was case referred to medical				V-08-01 18	26. Place of Dea			7.00	2010
<b>&gt;</b>	Physician: this certific ral director,	ToB	<b>S</b>	examiner? 1 ⊠ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/O	utpatier	nt 3□ DOA Othe	er: 4 🗆 Nursing H	ome 5 Res	idence 6	o ∰Other (Speci	<sub>ify)</sub> Scene
n of				<ol> <li>Manner of Death</li> <li>1 □ Naturat</li> <li>5 □ Pending</li> </ol>	28a. Date of Injur (Month, Day		Time o Injury	Worl	C?	28d. Describe	how injury	y occurred	c. 11
sio	teat tor:	Cati	5	2 Accident investig	ot be		46	_ M   10	Yes 2 No	Suhi	Commen	8/0/3	Sell
Division	i or Attend efter death Director: , d in by the f	Certification:		4 ☐ Homicide determin	28e. Place of Inju building, etc	:. (Specify)	arm, str	eet, factory, office		City or To	wn, State)	o Number of Aur	ral Route Number,
_	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by			29a. Certifier 1 ☐ Certifying	Physician: To the best of	of my knowledg	e, deat	h occurred at the tin	ne, date and place	, and due to the	cause(s)	and manner as	
	P Fu	edical	3		xaminer: On the basis of and manner sta	examination ar							
	To the within To the comp	Me		29b. Signature and little of certifier	(n.	`		29c. License	e number			e signed (Month	
				1/ Lan	-lokeau	)		OCI	Æ		Marc	ch 14, 2	2006
(9	3)02			30. Name and address of person v	who completed cause of de	eath (Item 23a)	(Туре,						1 01 001
/				31 Date filed (Horth Day Year)	o UE, My	y'e Signatura		111 Per	n Street	Baltin	nore,	Marylar	nd 21201
	S Regis	tate trar		31. Date filed (Month, Day, Year)		ar's Signature		Cooli					
	-			MAR 1 C	LUUU TOUR	150	13	The state of the s					

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 5:00P M 10, 2006 LILLIE ALICE MILLS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES BRADFORD OAKS NURSING &REHAB CENTER CLINTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year MAY 15, 15) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M XX F Months VIRGINIA 1914 219 32 0601 91 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23c or 28e-f shov Example must be collibed at XXYes 2 □ No Director PRINCE GEORGES CLINTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20735 7520 SURRATS ROAD death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: by Year or Dates: 3X Widowed 4 ☐ Divorced "neturel" ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CATERER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 ment of Health and Mental I THOMAS GLYN ANNA HAIRSTON 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3940 EXLEY PL. #412 SUITLAND, MD 20746 QUEENITA GASKINS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 03/14/06 ALEXANDRIA, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. SUITLAND, MD 20746 4308 SULTLAND ROAD 23a. Print Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovasculas Misease Immediate Cause (Final disease or condition resulting in death) therosderotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transif To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 Wo 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 XUnknown Completed HYPERTENSION been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: XXX Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes XXNo completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? : After Certification: 1XXNatural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funerel XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 3 13106 29c. License number 29b. Signature and title of certifier 52741 nu 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 CAROLINE CAINE 11701 LIVINGSTON RD. FT. WASHINGTON, MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2006 Registrar

			1 - For State Registrar	State of Ma	arylan		artmen rtificate			and M	_	giene Reg. No.	106	09702
	Physici		Decedent's Name (First, Middle, Last)     BEULAH MAE McRAE								2. Date of De Month	Day	Year 2006	3. Time of Death 1:50 P M
	/Medio Examin		4a. Facility Name (If not institution, give s SOUTHERN MARYLAND I				4b. Cily,		Location of	of Death		4c.	County of Death	
- 62	Funeral Director		5. Social Security Number 6. Sex 577-32-1566	7. Ag	9 (In yrs. 92	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/01/	ay, Year)	9. Birth NOR	nplace (State or Foreign IH CAROLINA
	Maryland a-f show ilied at	tor	10a. State 10b. County MD PRINCE GE(	ORGES		y, Town or Lo								10d. Inside City Limits Yes 2 □ No
	with the a or 28s	Direc	10e. Street and Number 4804 BIRCH TREE LAN	JF			10f. Zip						zen of What Co	untry?
980	be filed within 72 hours after death with the Maryland that Hygiene. Industrie then "natural", or Iteme 23a or 28a-f show other then "natural", or Iteme 23a or 28a-f show event. I'm Medical Examinar must be notified at	by Funeral Director		12. Was Decedent Armed Forces? 1 ☐ Yes ※XXI If Yes, Give Year or Dates:				lent of Hi	spanic Ori n, Mexicar Specify:	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)	USA o-	14. Race - Amer Stack, White Specify: BI	
21215-0036	e filed within 72 ho il Hygiene. other then "natur vent, the Medical i	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9TH		i+)	16a. Deced (Give life. SUPPLY	kind of wo DO NOT us	rk done a se retired	urina mos	t of work	ng	16b. Ki	nd of Business/I	Industry
Maryland ?	should be filed and Mental Hygi marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last) WILLIAM COX						ROSE	ANN	A THOMA	AS		
Man	s 1 and 2 should f Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) JESSIE BLACK/DAUGH										r Town, State, 2 ID 20744	
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 \( \bar{X}\) Burial 2 \( \subseteq \text{Cremation} \) 3 \( \subseteq \text{R}\)  4 \( \subseteq \text{Donation} \) 5 \( \subseteq \text{Other} \) (Specify)	3.000	(	Place of Disponentery, cremetery, cremetery	sition (Nar matory or o	ne of ther place	a)	[	) 2006	20c. Lo	cation - City or	Town, State
Balti	permit. Pages Department of Pimportant: If ite eny injury or of once.		21. Signature of Funeral Service License	nous ob	NO						SHALL'S UITLANI		ERAL HO	ME
	Physician		234. Parth. Enter the disease, or complication, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused ne cause on each li	the deal	h. Do not ent	ter the mod	e of dying	g, such as	cardiac		arrest,		Approximate Interval Between Onset and Death
8760,	Medical Examiner  hysicien and the purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consec	juence of):								,
.O. Box 68	death certific e ettending p ed for use as i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	∃Ectopic pr ∃ Other (sp						23d. Date of deli Month	ivery Day Year
S, D	Se G es	Ď	Part II. Other significant conditions con	ntributing to death b	ut not res	sulting in the u	nderlying o	ause give	en in Part I				01	the cause of death?
Record	The law ate has b page 2 si	Completed									24a. Was auto perf 1  Yes		24b. Were au prior to death?	itopsy findings available completion of cause of
Vital	sicien: certific irector,	Be	25. Was case referred to medical examiner?	lospital:	ant 2	] ER/Outpatier	nt 3 🗆 D0	Othe	30"		n (Check only		6 □Other (Spec	cifu)
o	ding h. After fune	ation: To	27. Manne-of Death  1. Natural 5   Pending 2   Accident investigation	28a. Date of Inju (Month, Da	ıry	28b. Time o Injury		28c. Injury Work			28d. Describe			cuy)
Division	i Pite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	ury - At h c. <i>(Speci</i>	ome, farm, st fy)	reet, factor	y, office				(Street an own, State		ural Route Number,
	e Hospitel 24 hours a re Funerel I letely filled	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	inian: To the best ner: On the basis of and manner st	f examina	wiedge, deat ation and/or in	h conumed vestigation	at tha tin , in my of	date an oinion, dea	of plane, ith occur	and due to the red at the time	date and	and manner and place, and due	to the cause(s)
	To the Pwithin 24	Me	29b. Signature and title of certifier				290	c. License	number	?/			e signed (Monti	
	E go		30 Name and address of reson to co	C / M	leath (Iter	m 23a) (Type,	Print)	103	77	- 4	Physic	ر (۱	10/06 rip 20	744
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 4 2006	32. Registr	ar's Sign	ature								,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day 2006 **Physician** Year Marion Mroczek March 7, 10:15AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bradford Oaks Nursing Home Prince George's Clinton, MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2፟ÞF Yrs. 7-16-1929 PA Director 76 174-22-5105 Usual Residence of Decedent with the Manyland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any hijury or other traumatic event, the Modeal Experimental be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ▼ Yes 2 No **Funeral Director** MD P.G. Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11802 N. Marlton Ave. 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify: δ Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adolf V. Mroczek Gertrude Petersheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11802 N. Marlton Ave. Upper Marlboro, MD 20722 Claire Brierton - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-10-06 ⁴ 4 □ Donation Ft. Lincoln Crem. Brentwood, MD 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Mari a 23a. Part1. Enter the disease, or complications in the bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic obstructive pulmonary disease vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 Yes 2X No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 🗌 Yes 2∑ No 2 ER/Outpatient 3 DOA 1 Inpatient ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred . After Certification; 1 X Natura! 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No М 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a 29a Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-18545 March 9, 2006 s of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, M.D. 12020 Old Line Center Suite 207 Waldorf, MD 20602 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 1 4 2006

			1 - For State Registrar	State of Maryland / Depa Cer	artment of Health and I tificate of Death	Reg	ene 2006	09704
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     WILLIE	JAMES MARTI	N	2. Date of Death Month MARCH	<sup>Day</sup> 2006	3. Time of Death 5:05A M
}	Examin		4a. Facility Name (If not institution, give st MANOR CARE NURSIN		4b. City, Town, or Location of Death	h	4c. County of Death PRINCE GE	ORGE'S
	Funeral Director		5. Social Security Number 6. Sex 579-42-1894	M 2□ F 7. Age (In yrs. last birthday)  84 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y		lace (State or Foreign
	rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		1	Od. Inside City Limits
	e Many Sa-f sh	ctor	MD PRINCE GEO	ORGE'S UPPER	MARLBORO			1X Yes 2 □ No
	23e or 20	ai Dire	10e. Street and Number 12703 PRINCE LEIGI	H STREET	10f. Zip Code 20774		g. Citizen of What Coun U.S.A.	ntry?
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Exprings right be roulled at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1⊠Yes 2 □ No NAVY	Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerli⊓ Yes 2☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	d within 72 hi giene. er then *natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  (Give life. L	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)  ALESMAN	rking 16	Sb. Kind of Business/Inc	dustry
and	d be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last) UNKNOWN		18. Mother's Nar	me (First, Middle, Ma		
aryl	should be and Mental s marked c	2	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mailin	VELMI og Address (Street and Number or Ru			Code)
e, M	1 and 2 Health a em 27 is ther tra		THELMA L. MARTIN/V	VIFE 12703  20b. Place of Dispo	PRINCE LEIGH ST		LBORO, MARY	
mor	a 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemetery, cren	natory or other place)		IVERDALE , MA	
Balti	permit. Page Department Importent: if eny injury o		21. Signature of Furneal Service Licenses	22	. Name and Address of Facility $ J  . $	B. JENKI	NS FUNERAL	HOME
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not ent-	474 LANDOVER ROAD or the mode of dying, such as cardiac			Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	ADVANCED DEMENT	I.A			Interval Between Onset and Death
	/Medical Examiner		ſ	Due to (or as a consequence of): PARKINSON DISEAS	SE			
	ed	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a consequence of):  CORONARY ARTERY	DICEACE			
60,	ificate be executed g physicien and as the burial-transit	I Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	DISEASE			
68760,		ledical	d.			-		
P.O. Box	The law requires thet the death certifule has been signed by the ettending rage 2 should be deteched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
ds, P	uires thet signed b ild be dete	ρ	Part II. Other significant conditions cont	ributing to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the	
Division of Vital Records,	n: The law requir icate has been si r, page 2 should I	Completed				24a. Was an autopsy performe	prior to cor	psy findings available inpletion of cause of 2⊠ No
<u> </u>	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	ath Check only one)	ce 6 ☐Other (Specify	()
o uoi	Attending Physician: r death. ector: After this certifically the funeral director.		27. Manner ol Death 1 ଔNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how		,
Divis	2 # # E	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, larm, str building, etc. (Specify)	eet, lactory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	e Hospitai 24 hours a Eunerai C	Medical	29a. Certifier 1⊠ Certifying Physi (Check only one) 1⊠ Medical Examin	cian: To the best of my knowledge, death Br: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the causerred at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	h / ?	29c. License number	29d	I. Date signed (Month, I	
0	(10)		30. Name and address of person who con	poleted cause of death (Item 23a) (Type	5 7 5 8 1 Y	2	3-14-0	06
	(1)		C. DONALD GEORG	E M.D. 7305 HANOVER		GREENBELT	Γ, MARYLAND	20770
	Sta Registr		31. Date liled (Month, Day, Year)	. Registrar's Signature	BI			

Physic /Med Exam

**Funera** Directo

State of Maryland / Department of Health and Certificate of Death	Mer
	1

For State Registrar	State of Maryland	•	artment of I <i>rtificate of</i>		nd Mental H	ygiene Reg. No.	006	09705
Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death
FLORENCE		MCNE	ILL		MARCH	9 Day	2006 Year	6:40 PM
4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of			County of Deat	
MANOR CARE NURSIN	NG HOME		LARGO			PR	INCE GEO	ORGE'S
5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24		irth 19	33 9. Birt	hplace (State or Foreuntry)
578-42-9133	M 20XF 73	Yrs.	Months Days	Hours	FEBRU	ARY 2		SISSIPPI
Usual Residence of Decedent								
10a. State 10b. County		, Town or Lo	ocation					10d. Inside City Lin
MD PRINCE GE	ORGE'S UP	PER MA	ARLBORO					Yes 2□
10e. Street and Number	"		10f. Zip Code			-	zen of What Co	untry?
	# 402		20774				U.S.A.	
	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Originan, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	10-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:			Specify:	BLACK
3 Widowed 4 Divorced	Year or Dates:							
15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	durina most o	of working	16b. Ki	nd of Business	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	0)				
17. Father's Name (First, Middle, Last)	5+	DEI	NTIST	19 Mathad	s Name (First, Midd		RIVATE	
LLOYD G. MCNEILL	CD						Jurname)	
		401 14 11				CKER		
19a. Informant's Name/Relationship (Type		1.			or Rural Route Num	111		
ALBERT MCNEILL  20a. Method of Disposition	SR./BROTHER	_	I/ Ist ST osition (Name of	REET N	.W. WASHI	+-	DC 20	0001
1 ☐ Burial 2 ∰ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	iemovai from State	/ERDAL	matory or other pla	DRY 3	3/15/06	RIVE	ERDALE,	MARYLAND
21. Signature of Funeral Service Linear			2. Name and Addre 7474 LANI	Olders Condition of	J. B. JE COAD LANDO			
23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	ne cause on each line.		ter the mode of dyi		ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a consequ	uence of):						
	PNEUMO	NIA						
Sequentially list conditions, if any, leading to immediate	Due to for as a consequ	uence of):						
cause. Enter Underlying Cause (Disease or injury that initiated events	HYPERL	IPIDEN	AIA					
resulting in death) Last	Due to (or as a consequ	uence of):						
	BACTER	EMIA.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1   Live birth 2   Fetal 4   Pregnant at time of de 9   Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of del Month	ivery Day Year
Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	underlying cause gr	ven in Part I.		tobacco u		the cause of death
					per	is an copsy formed?	prior to death?	utopsy findings avail completion of cause
25. Was case referred to medical				26. Place of	f Death (Check onl)		1 2 103	20.00
examiner? 1 ☐ Yes 2 ☒ No	lospital: 1   Inpatient 2	ER/Outpatie	nt 3□ DOA Ott		ing Home 5 Re		6 □Other (Sne	cilv)
27. Manner of Death  1 Anatural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju		28d. Describe			
3 Suicide 6 Could not be determined	2Be. Place of Injury - At ho building, etc. (Specify	me, farm, st			28f. Location	(Street an own, State	d Number or Ri	ural Route Number,
	.1				111			

31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar

MEKLIP WORKNEH M.D. 7705 BELLE POINT DRIVE GREENBELT, MARYLAND 20770 Registrar's Signature

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

D0062116

MARCH 13, 2006

		1	For State Registrar	State of Maryland		artment of I <i>tificate of</i>			JIENE Jeg. No.	)6	09706
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Vaar	3. Time of Death
	Physicia		DENARD	MASON				March	07	2006	12:16 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death		4c. Cou	nty of Death	
			Blacklog Street @	Dateleaf Aven	ue	Capita	al Height'				eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year 196	7 9. Birth	place (State or Foreign intry)
	Director		5/8-92-2166	M 2□F 38	Yrs.			NOVEMBI	ER 19	WASI	HINGTON, DC
	D		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	aryla sho	5									12€ Yes 2 No
	he N	Director	MD PRINCE GE  10e. Street and Number	ORGE'S D	ISTRIC	T HEIGHT	<u> </u>	1	10g. Citizen	of What Cou	intry?
	with a or		7123 Chapparal D	rive		20747	7		US	A	
	eath	eral		12. Was Decedent Ever in U.S	5. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		Race - Amer	
0	be filed within 72 hours after death with the Maryland at Hygiene. A the Hygiene do they than "natural" or items 23a or 28e-f show avent, the Modical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, specify Cul 1 □ Yes 2 🖾 No		Rican, etc.)		Black, White scify: B1	
21215-0030	hou		15. Decedent's Educ		16a. Dece	dent's Usual Occu	pation		16b. Kind o	f Business/li	ndustry
Ò	within 72 ene. then "net	olet	(Specify only highest grade	completed)	(Give life.	kind of work done DO NOT use retir	eduring most of work ed)	king			
7	iene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	P1	umber			Pr	ivate	
	e filed v al Hygie I other t vent, in	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sun	name)	
<u>a</u>	Aental Aental rked o	To B	James Wyatt				Alexis	Mason			
Maryland	should ind Men marke umatic		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ng Address (Stree	at and Number or Ru	ral Route Numbe	r, City or To	wn, State, Z	ip Code)
	and 2 Balth a n 27 is		Sherron Mason/ Wi				al Dr., D				
<u>6</u>	_ + = =		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	20b. Pl	lace of Dispo emetery, crei	sition (Name of matory or other pl	ace)	Date	20c. Locati	on - City or T	Fown, State
Ē	Page nent can int: If		4 □ Donation 5 □ Other (Specify)	Har	mony 1	1emorial	Park 03/1	13/2006	Landov	er, M	aryland
Baitimore,	permit. Pages 1 Department of H Important: If Its any Injury or ot once.		21. Signature of Fundad Service License		1		ress of Facility J. lover Rd.,				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	n. Do not en	ter the mode of dy	ying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final	Gursho	+ Wou	and to	chest				Onset and Death
ر	/Medical		disease or condition resulting in death)	Due to (or as a consequ							
	Examiner										
	سيج	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ranica off)n						
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	o						_	
Ö,	e exe	Ä	resulting in death) Last	Due to (or as a consequ	dence of):						
8760,	cate be executed physicien and s the burial-transit	dlcal		d					_	-	
9	- On 65		IF FEMALE:	23c. If ves. outcome of pregna					024	D-44 dell	
Box	es that the death certific igned by the attending p be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal	death 3	⊒Ectopic pregnar ⊒ Other (specify)	ncy		230	Date of deli Month	Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eain Si	_ Other (specify)					
Д.	hat the	문	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	inderlying cause o	given in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Vital Records,	The law requires that the ste hes been signed by th page 2 should be detache							101	Yes 2 N	lo 3 Pro	obably 4 Unknown
Ö	w requir been si should	Completed			-			24a. Was	an 2	4b. Were au	topsy findings available
ě	hes hes	ш						autor perfo	osy ormed?	death?	completion of cause of
_ 			25. Was case referred to medical			271004	GC Disco of Dog	1 X Yes	2 No	1 □XYes	2□ No
₹	ysician: The lav is certificete hes director, page 2	Be	ovaminor?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	)th on	iome 5 ☐ Resid	_	Other (Sne	situl Scana
ō	Phys r this oral di	5.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe I			
o	ding h. After funer	ţ.	1 □Natural 5 □ Pending 2 □ Accident investigation	3/7/06	Injury 17:00	p M 1	vork? □Yes 2⊠No	Shot	- by F	police	2
Division of	Attanding Physician: r death. sctor: After this certifice by the funeral director.	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, st	treet, factory, office	ee .	28f. Location (	Street and N	lumber or Au	ural Route Number,
á	al or safte i Dir d in t	Certification:	4 Homicide determined	building, etc. (Specif				Leaf	Aue	Capi	ogst@Date_
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1. Certifying Phy (Check only 2. Medical Exami	rsician: To the best of my kno iner: On the basis of examina	wledge, dea	th occurred at the	time, date and place	a, and due to the	cause(s) an	d manner as	stated.
	in 24 hs Fi hs Fi	edical	one)	and manner stated.				1			
	To the l	Σ	29b. Signature and title of certifier	. 0		29c. Lice	ense number				h, Day, Year)
	(		· Carde Ha	llan Nd		OC	ME		March	8, 20	06
0	(6)		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type		enn Street	- Rol+i-	oro 1	Marsol a	nd 21201
1			31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature		em priee	L Dalli	ore, I	агута	IIU ZIZUI
	St Regist	ate	MAR 1 4 7006		S do	alle)					

			For State Registrer	State of Marylan		artment of H			211	06	09707
					Cel	illicate of	Dealli	2. Date of Dea	Reg. No.	00	03101
32	Phýsicia	an 5	Decedent's Name (First, Middle, Last)					Month	Day	Year	3. Time of Death
	/Medic		Renee Den		orton			March		2006	5:28 A M
	Examin	er	4a. Facility Name (If not institution, give s				r Location of Deatl	1		ty of Death	
		92	Prince Georges Hos	pital		Cheve	-		Princ	e Geo	rges
1 20	Funeral		5. Social Security Number 6. Sex	7.5		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th y, Year)	9. Birthp	place (State or Foreign htry)
	Director		213-84-9920	IM 2₫F 43	Yrs.			July 18	1962	Conn	ecticut
	p .		Usual Residence of Decedent	10- 60							04 1-14 00 11-14
	how	_	10a. State 10b. County		y, Town or Lo					,	0d. Inside City Limits
	Ba-f.	cto	MD Prince Geo	orges UI	pper M	arlboro					12⊈Yes 2 □ No
	th th	Director	10e, Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a	a	298 Harry S. Truma	an Dr.		2077	4			USA	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14. Ra	ace - Americ	
9	or its		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2X No		0 1 110411, 01017		ify: Bla	
8	72 hours after death with the Maryland naturel', or items 23e or 28e-f show alcel Examine must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		12 103 242 110	Specify.		Spec	пу: БІа	.CK
2-0	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occup kind of work done	ation	kina	16b. Kind of	Business/In	dustry
7	within ene. then	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
2	e filed within al Hygiene. I other then vent, the Me	5	10th			Cook			Go	vernme	ent
ğ	be filed tal Hygi d other event,	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Suma	ime)	
<u>a</u>	Menti Menti rkeo	2	Harvey Morton				Cosie	Benton	Į.		
Maryland 21215-0036	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	iral Route Numbe	er, City or Tow	n, State, Zip	Code)
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other treumatic event, the Madical Examinational be notified at it.		Turena Morton/ Sis	ster	298 н	larry S.	Truman Dr	., Upper	r Marlb	oro,M	D 20774
Baltimore,	it He other		20a. Method of Disposition	_	lace of Dispo	osition (Name of matory or other pla		Date	20c. Location	- City or To	ARYLAND
Ë	Pages nent of I int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			E JONES C		1/2006	CHESAPE	ΔKE B	FACH
≣	permit. Pag Department Important: I eny injury o	i	21. Signature of Funeral Service License	27 28	22	2. Name and Addre	ss of Facility J	.B. Jenk	ins Fur	neral	Home
Ba	Depa Impo eny i		KAN	6100		7474 Land	0.1515			20785	
4	-		23a. Part1. Enter the direase, or compli	cations that caused the deat							Approximate
#	*		shock, or heart farlure. List only or Immediate Cause (Final	ne cause on each line.			_				Interval Between Onset and Death
hice	Physician /Medical		disease or condition resulting in death)	11/2145	,47	1	DIE	4 51 (	TIVE	tr	
7.3	Examiner			METAS  Due to (or as a conseq  MALIGN	uence of):	- 01	6.40	L/ _	: 66		
	₹************************************	<u>.</u>	Sequentially list conditions,	Due to (or as a conseq		, 1	eunn	CR		23/02	
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	230 10 (01 23 2 001364	derice 01).						
_	and I-trar	хап	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					-	
760,	ate be executed hysicien and he burial-transit	caiE			.,.						
87	3 × 8			l							
к 68	death certificat e attending phy of for use as th	Me	IF FEMALE:	0 16							
Вох	ath o	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	⊒Ectopic pregnanc	y			ate of delive fonth	ory Day Year
	0 0 0	Sic	1 ☐ Yes 2 ☐ No 9 ☒ Unknown	4☐Pregnant at time of d 9☐Unknown	eath 5	☐ Other (specify) _					24)
P.0	The law requires that the sie hes been signed by th page 2 should be detache	Physician/Med									
	es tha igned be det	þ	Part II. Other significant conditions cor	thouting to death but not res	ulting in the u	inderlying cause giv	en in Part I.				ne cause of death?
Vital Records,	w requir been si should	ed						10	Yes 2 ☐ No	3 □ Prob	pably 4 Dunknown
သို့	e law n hes be je 2 sh	Completed						24a. Was			psy findings available mpletion of cause of
m	The The page	E						perfo	rmed?	death?	2100
tal		0	25. Was case referred to medical				26. Place of Dea	ath (Check only o			
>	Physician: this certific ral director,	0 0	examiner?	lospital: Inpatient 2	ER/Outpatier	nt 3 DOA Ott	ner: 4 ☐ Nursing F	lome 5 ☐ Resid	dence 6 □0	ther (Specif	v)
of		L i	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	28d. Describe			
0	th. : After s funer	tio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1	Yes 2 □No				
Division	after death. Director: After	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, st	reet, factory, office				ber or Rura	al Route Number,
Ö	afte Dire	Certification:	4 Homicide	building, etc. (Specif	Y)			City or To	wn, State)		
	Hospital 24 hours a Funerel E etely filled		29a. Certifier 12 Certifying Phys	sicien: To the best of my kno	wledge, deat	h occurred at the ti	me, date and place	, and due to the	cause(s) and r	nanner as s	tated.
	P Ho 24 P Fu e Fu	Medicai	(Check only 2 Medical Examinate)	ner: On the basis of examina and manner stated.	tion and/or in	ivestigation, in my	ppinion, death occu	irred at the time,	date and place	, and due to	the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of cortifier			29c. Licens			29d. Date sign	ed (Month,	Day, Year)
		: 1						2	0 .		
	- 5 - 0		, ,			- 17	) X / S		/ _ /	-7	00/
ß	1		30 Name and address of assess with a	ampleted cause of death fire-	23a) /Tues	Print	0818		3-1	-2	006
f	2		30. Name and address of person who co	empleted cause of death (Item	1 23a) (Type.	Print)	1818	havari	3-1	-2. n s	1785
f	Sta	te	30. Name and address of person who co	ompleted cause of death (Item	01 H	Print) HAL	DrC	heveri	3-1	-2. D 2	006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** March 12. Randolph Egerton Milne 2006 8:57 P /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Temple Hills Prince George's 5306 Frazier Terrace If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, July 2, 1922 Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 83 Guyana Director 578-82-2917 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heetith and Mental Hygiene. ent: If them 27 te marked other than "natural; or Itame 23s or 28s-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Maryland Temple Hills Prince George's 1 Yes 2XXNo Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 20748 5306 Frazier Terrace Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married **Black** If Yes, Give Year or Dates: 1 ☐ Yes 2 ◯XNo Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Washington Post 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Annie Lancaster မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5306 Frazier Terrace Temple Hills, Maryland Joy Milne-Henry / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MX Burial 2 Cremation 3 Removal from State permit. Page Depertment o Importent: If eny injury or 5 03/17/2006 Harmony Mem'1. Park Landover, Maryland 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part :Énter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) PROSTATE CANCER METASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the ettending physicien for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificete has autopsy performed 1 Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes 2/ No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death. To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059942 March 13, 2006 30. Name and address of person who completed cause of de tem 23a) (Type, Print) 8926 Woodyard Rd., Ste #201 Clinton, Maryland 20735 Deepnarayan Tiwarri MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 5 2006

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2. Registrar's Signature

	1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and M tificate of Death	ental Hygiene Reg. No.	UU0 UJ/UJ
Physician	Decedent's Name (First, Middle, Last)  Ruby Lee Grubbs Meyers		2. Date of Death Month Day March 7,	Year 3:15a M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
Examinor	Suburban Hospital	Bethesda		Montgomery
Funeral Director	5. Social Security Number 238-20-3501 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) 1 □ M 2 ☑ F 83 Yrs.		8. Date of Birth (Month, Day Year) DEC 10, 1	
death with the Maryland me 23a or 28a-f show mers traust be notified at neveral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
a-f s	Maryland Montgomery North Bethe	sda		1 ☐ Yes 2 🗷 No
or 28	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
23a rith wi	10201 Grosvenor Place, Apt. 1111	20852		USA
5 £ 8 5	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe I Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 <b>∑</b> No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-00 ed within 72 hou yeglene. sy the marical E., the marical E.	15. Decedent's Education (Specify only highest grade completed) 16a. Deced (Give	lent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16b. Ki	ind of Business/Industry
withir than	Elementary/Secondary (0-12) College (1-4or 5+)	fessional Singer	Sh	now Business
Hygin CO	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	
Vland Vland Vuld be fil Mental H Mrked ott	Cyrus Grubbs	Minnie N	White	
Maryland 2- 12 should be filed v 12 should be filed v 12 marked output 14 marked ovent, th To Be Co		ng Address (Street and Number or Rura	•	
C, Z				orth Carolina 28409
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours att Depertment of Health and Mental Hygians. The my potential if then 27 is marked other than "natural", or my holury prother traumatic event, the Madical Exembance.	1 Suburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cate of Hear	natany or other placel	h 15, 06 Silv	position - City or Town, State  rer Spring, Maryland
m ggega	Dang 2816. 50	O University Blvd	, W, Silver	Spring, MD 20901
68760, Iliticate be executed as the burial-transit edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  Sequentially list conditions.  any law ing to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		r respiratory arrest,	Approximate Interval Between Onset and Death
ecords, P.O. Box 68 law requires thet the death certific as been signed by the attending plass should be detached for use as a should be by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Cords, Pwrequires the been signed I should be det	Part II. Other significant conditions contributing to death but not resulting in the uncolon Cancer	nderlying cause given in Part I,	23e. Did tobacco u	use contribute to the cause of death?
. r r o - 2   E			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of Vital F  Of Vital F  Physicien: Th  r this certificate ral director, page.	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
2 2 2 E	1 ☐ Yes 2 No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient		me 5 Residence	6 ☐ Other (Specify)
ding After tune then	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year) Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injui	ry occurred
कि विश्व द	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, a)
Hospi Hospi 4 hour Funar Tely fill	29a. Certifier  (Check only one)  1 **Certifying Physician: To the best of my knowledge, deatled.**  2 **Medical Examiner: On the basis of examination and/or in and manner stated.**	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(s	) and manner as stated. d place, and due to the cause(s)
To the Hos within 24 h To the Fur completely	29b. Signature and title of court ler	29c. License number	29d. Da	te signed (Month, Day, Year)
	MD MD	D60117	Mar	ch 7, 2006
	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) ter Drive, Rockvi	lle. MD 208	350
State				
Registrar	MAR 14 2006	entil .		

			1 - For State Registrar	ate of Marylar			t of He		d Mental H	ygiene Reg. No.	006	097	10
	Physici	an	Decedent's Name (First, Middle, Last)		100	-11			2. Date of D Month	Day	Year	3. Time of	
	/Medic	al	Isaiah		yn,	Hon		1 1 1 1 1 1 1 1	March	03	2006 unty of Death	7:45	<b>P</b> M
	Examin	er	4a. Fecility Name (If not institution, give stree 2901 Unit C, 2nd Ar				rt Me	Location of E	eath		ne Aru		
	Funeral Director		5. Social Security Number 575.99.9174 6. Sex 1 西 M	7. Age (In yrs. 1	last birthday) Yrs.	If Unde Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of B Win. (Month, D March	irth (ay, Year) 6, 2004	9. Birth Con Hav	nplace (State o untry) Vaii	r Foreign
	and **		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside Ci	tv Limits
	death with the Maryland ms 23a or 28a-f ahow rmust be notified at	tor	Maryland Anne Arunde	el F	ort Mea	ade						1X Yes	
	or 28s	Director	10e. Sireet and Number			10f. Zip	Code			10g. Citizer	of What Co	untry?	
	ath w		2901 Unit C, 2nd Arr		5		0755		0.10	U.S			
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2 Q	72 ho	eted	15. Decedeni's Educatio (Specify only highest grade cor		16a. Deced	kind of wo	rk done di	uring most of	working	16b. Kind	of Business/I	ndustry	
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Mar	12 sho h and 7 is m		19a. Informant's Name/Relationship (Type, F Anquita M. Milton/Mo	•					ny Drive,				
<u>ნ</u>	tsm 27		20a. Method of Disposition	20b. F	Place of Dispo	sition (Na	ne of		Date Dire		ion - City or		ıa
Ë	Pages Intent of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	varirom State	emetery, crer lingtor	-			3/10/2006	Arlin	gton,	Virgin:	ia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Deperment of Headib and Menta important: if itsm 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	anti	H11	NES-	d Address RINAI New H	DI FUI	NERAL HOM Lre Ave,	E, INC Silver	Sprin	g, MD 2	20904
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the deat use on each line.	h. Do not ent	er the mod	le of dying	, such as car	rdiac or respiratory	arrest,		Approximate Interval Bett Onset and I	eath
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Box	death certific e attending p od for use as i	Physician/Me	23b. Was decedent pregnant 23c. If	yes, oulcome of pregna □Live birth 2 □ Feta	ildeath 3□	Ectopic p				23d	. Date of deli		/ear
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o. O.	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions contribu	iting to death but not res	ulting in the u	nderlying o	ause givei	n in Part I.	23e. Did	tobacco use	contribute to	the cause of d	eath?
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	To the Hos within 24 hy To the Fur completely	Med	29b. Signature and title of certifier	Single States		29	c. License	number		29d. Date s	igned (Month	Day, Year)	
	1		> letter mo				04	11444	′	march	07,	2006	
	9		1/-	eted cause of death (Item  MO GOO N  32. Registrar's Signi	n 23a) (Type,	Print)	Trace of	- 10	them 10	WIN I	run al	1/100	
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			1 - For State Registrar		State o	f Marylar			of Health and of Death	Mental Hy	ygiene Reg. No.	06	09711
	Physic /Medi		1. Decedent's Name (First Mary Elizab							2. Date of D Month March	Day	006 <sup>Year</sup>	3. Time of Death 4:04 A M
•	Exami		4a. Facility Name (If not in Suburban Ho		street and nu	mber)		4b. City, Tov Bethe	vn, or Location of Dec	ath		inty of Death	
	Funeral Director		5. Social Security Number 577-34-3530	1	х ] м 2[ <b>X</b> [F	7. Age (In yrs. <b>7</b> 6		If Under 1 Y Months D	ear If Under 24 H ays Hours Mi	n. (Month, D	irth 2ay, Year) 14,1929	9. Birthi Cou. Wash	place (State or Foreign ntry) ington D.C.
	•how	٥	III.	County			ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2√ No
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	3a or	0	815 Crother	s Lane				208				d Stat	•
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show ony injury or other traumetic event, the Medical Examinar must be notified at goods. ← Company.	by Funeral Director	11. Marital Status  1 Never Married 2  3 V Widowed 4 D	☐ Married	12. Was Dece Armed Fo 1 Tyes If Yes, Gir Year or D	2∏No ve	1		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0- 14.	Race - Ameri Black, White,	can Indian,
1	Maryland 21215-0035 d 2 should be filed within 72 hours alt th and Mental Hygiene. 77 is marked other than "naturel", or traumetic event, the Medical Exernit	Completed	15. Do (Specify only Elementary/Secondary)	ecedent's Edu highest grad	cation		(Give		ccupation one during most of w stired)	rorking		of Business/In	•
	Bnd 21	Be Cor	12 17. Father's Name (First, I Samuel Atwe				Manag	ger		ame (First, Middle	e, Maiden Sun		vernment
	Marylis	2	19a. Informant's Name/Re John McCaul	lationship (Ty	rpe, Print)				reet and Number or I	Rural Route Numi	ber, City or To	-	
	Balttmore, bermit. Pages 1 ar Department of Hea mportant: If Item; nny injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cren 4 □ Donation 5 □ O	nation 3 🗆 F	Removal from		Place of Dispo cemetery, crem te of	sition (Name o	of place) Mar	ch 14,	20c. Locati	on - City or To	
1	Balta permit. Departm Importa eny inju		21. Signature of Funeral S		ND)		22	. Name and A	<sup>ddress of Facility</sup> De Deer Park	Vol Fune	eral Ho	me	
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~	UIVISION OT VITAI HECOIDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the attending physician. completely filled in by the funeral director, page 2 should be detached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month- 1 □ Yes 2 No 9 □ Unknown	arit	1□Live b	tcome of pregna pirth 2  Feta nant at time of d own	Ideath 3	Ectopic pregn Other (specif			23d.	Date of deliver	ery Day Year
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The state of the s	The law recate hes been page 2 sho	Complet	Hepatic	sinho	sis di	ne to	No pat	715		24a. Wa auto perf 1 🗆 Yes	ormed?	Ib. Were auto prior to co death? 1 \( \sum \subseteq \text{Yes}	opsy findings available impletion of cause of
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mary metauley	VISION OT VITAI HEC Attending Physician: The law death. ector: Alter this certificate hes b by the funeral director, page 2 si	ation: To	2 Accident	Pending investigation	100	Inpatient 2 🗋 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	28c.	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 Res			(y)
578	DIVISION To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place buildi	of Injury - At hong, etc. (Specif	ome, larm, stre	eet, lactory, of	lice		(Street and Nu own, State)	ımber or Rura	al Route Number,
M	the Hospital hin 24 hours e the Funeral i	Medical	N A Seno	edical Exami	ner: On the b	a best of my kno asis of examina ner stated.	wledge, death tion and/or inv	estigation, in r	ne time, date and pla my opinion, death oc	ce, and due to the curred at the time	, date and place	ce, and due to	the cause(s)
	15 15	-	- Moll	certified.	Ull	MD (	00:1	0	2153)		. 4 1 1	gned (Month,	Day, Year) 2006
			30. Name and address of Dr. Peter G						town Rd.	Rockvil:	le, Md.	20852	2
	St Regist	ate rar	31. Date liled (Month, Day MAR		32.	legistrar's Signa	iture	ale	- 1				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Yeer **Physician** 0655 M Merrill 16 w. John 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Coastal Hospice at the Lake Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X**M 2□ F Yrs. Director 02-16-1925 216-16-7060 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Iteme 23a or 28s-1 ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other then "naturel", or iteme 23a or 28a-f ehow treumatic event, the Madical Examinar must be notified at Yes 2 □ No Director Princess Anne Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT # 308 21853 USA 30360 Maple Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑₩ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Mechanic Automobile Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Levin Merrill Hazel Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30360 Maple St., Apt. 308, Princess Anne, MD 21853 Mary Ann Merrill/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 0 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. 4 □Donation 5 □Other (Specify) Beechwood Cemetery 03/20/2006 Princess Anne, MD 22. Name and Address of Facility
Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Consistine disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 Impatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending 1 Yes 2 No death investigation after death Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 026278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David E. Couch, NO Coastel 1733 HISPIL 31. Date filed (Month, Day, Year) 32. Registar's Signature State MAR 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Miller Charles March 13, 2006 9:55 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**X** M 2□ F 229-44-8500 Yrs. July 18,1934 Virginia Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Jefferson Frederick Maryland by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21755 USA 3382 Point of Rocks Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 ₩ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Carman 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Baker Miller Grace Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3382 Point of Rocks Rd. Jefferson, MD 21755 Mary R. Miller/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any ir jury or once 3/16/2006 Jefferson, MD St. Pauls Ch. Cem 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 1100 North Maple Ave., Brunswick, MD 21716 23a. Part Enter the disease shoc or heart failure Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List may no cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Centro Varianen Accidente Et. & ma disease or condition resulting in death) Due to (or as a consequence of): Anterio nuevoliz Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury Atria sibullation that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) \_ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chranz ohtrucher 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 Ho 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Harsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Cerlification:

/Medical Examiner death certificate be executed burial-transit 68760, P.O. Records, Vital After d in by the

other traumatic event, the Medical Examiner must be notified at

al Hygiene.

Mental

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hayle

Baltimore, Maryland 21215-0036

within 24 hours aft

To the Funeral Di

completely filled in ro the State Registrar 5 Pending investigation 6 Could not be

determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier tout mo

1 Avatural

2 Accident

3 🗌 Suicide

29a. Certifier

Medical

4 Homicide

29c. License number P1081 A

29d. Date signed (Month, Day, Year) MARCH 13, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vasant Datta 340 Mill St. Hagerstown, Maryland 21740 301-739-7100

MAR 1 6 2006

Amend #26 per Phy. 3-14-06 A.A.Co.Health Dept.PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 = For Amend Item 23a State of Maryland / Registrar	Certificate of Death		Reg. No.
D1		1. Decedent's Name (First, Middle, Last)		2. Date of De. Month	ath Day Year 3. Time of Death
Physici /Medi		Eugene Edgar M	Myer	March	8 2006 7:20 a <sup>h</sup>
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death
		332 North Drive	Severna Pa	ark	Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birt Min. (Month, Da	th 9. Birthplace (State or Foreig Country)
Director		236-03-0908 <sup>1∑M 2□F</sup> 90	Yrs.	Min. (Month, Da Aug. 12	, 1915 West Virginia
pr _		Usual Residence of Decedent			
show	_	10a. State 10b. County 10c. City, Tor	own or Location		10d. Inside City Limit
e Ma	cto	MD Anne Arundel Se	everna Park		1 ☐ Yes 2 XX
다 다 9.28	lre	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
th w	] e	230 McKinsey Road	21146		USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23e or 28e-f show say injury or other traumatic event, the Medical Exament must be notified at any injury.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 No Specify		14. Race - American Indian, Black, White, etc. Specify: White
2 ho	Completed	15. Decedent's Education 16:	Sa. Decedent's Usual Occupation	-	16b. Kind of Business/Industry
Man 7	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	st of working	
d wit	PO		hysician		Medicine
oth oth ont,	Be	17. Father's Name (First, Middle, Last)	18. Moth	er's Name (First, Middle,	Maiden Sumame)
ld be lenta ked ic e	ToB	Benton D. Myer	Alci	ndia Norris	
Shound M	-	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Numb	er or Rural Route Number	er, City or Town, State, Zip Code)
ith a		H. Jane Myer (Wife) 2	230 McKinsey Road,	Severna Pa	rk. MD 21146
Hea Hear Term			of Disposition (Name of tery, crematory or other place)	Date	20c. Location - City or Town, State
nt of int or		A Buriar 2 Cremation 3 Chemovarilon State		2 11 2006	
rtant rtant			vin Memorial Cem.		Millersville, MD
permi Depa Impor any ir		21. Signature of Seneral Service Licensee	22. Name and Address of Facility Hardesty Fune 12 RidgelvAve	eral Home, P	P.A. Dis, MD 21401
icate be executed with physician and burial-transit sthe burial-transit	edical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  LEVA L  Due to (or as a consequence of the	Ype I Insulin		
rnat the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Featal deal 4 Pregnant at time of death			23d. Date of delivery Month Day Year
signed of be det	۵	Part II. Other significant conditions contributing to death but not resulting  Coronary Artery Disease	; in the underlying cause given in Part	1. 23e. Did to	obacco use contribute to the cause of death? Yes 2∜No 3 ☐ Probably 4 ☐Unknow
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has has	Completed			24a. Was autor perfo 1 Yes	
n: The icate I	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	e of Death (Check only o	Lauriuer S
certificate l rector, page		T Tes 2/25/10 T Inpatient 2 EH/C	Outpatient 3 DOA 4 N		dence 6 MOther (Specify) Residence
rnysician: Ine this certificate b al director, page	၉		D. Time of 28c. Injury at Work?		how injury occurred
After this certificate to uneral director, page		1 Natural 5 Pending (Month, Day Year)			
or Attending Physician: The after death. Director: After this certificate h in by the funeral director, page		2 Accident   5 Pending   2 Accident   3 Suicide   4 Homicide   Could not be determined   28e. Place of Injury - At home, building, etc. (Specify)	M 1 Yes 2		Street and Number or Rural Route Number, wn, State)
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ling Physician: Th After this certificate iuneral director, pag		2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled; and manner stated.	M 1 ☐ Yes 2 ☐ farm, street, factory, office  dge, death occurred at the time, date an and/or investigation, in my opinion, decorated as the time of t	28f. Location (city or Town  nd place, and due to the ath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	edical Certification;	2 Accident 3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)  29a. Certifier (Check only)  Medical Examiner: On the basis of examination as	M 1 ☐ Yes 2 ☐ farm, street, factory, office	28f. Location ( City or Tou and place, and due to the ath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
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			Registrar  1. Decedent's Name (First, Middle, Li	astl	- 06	illilli	ile OI L	Calli	2. Date of Dea	th		3. Time of Death	
	Physici		Elizabeth Nall						Month March 1:	Day	006 Year	12:05 P <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. Cit	y, Town, or	Location of Deat		<del>-i</del>	County of Deal		
			Harborside Larki	n & Chase			Bowie	9		1	ince Ge	eorge's	
	Funeral Director		216-46-9283	5-9283 1 M X F 92 Yrs. Months Days Hours					8. Date of Birth (Month, Day June 14	Year) , 19	9. Bin Co 13 Mar	hplace (State or Foreign ountry) Yland	
e, Maryland 21215-	and **		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation	<del></del>					10d. Inside City Limits	
	Many!	ō	,	George's		wie						1X Yes 2 □ No	
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of							zen of What Co	ountry?		
	th wit	al D	15005 Health Cent	er Drive			20	716			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 ☐ Yes 2 ☐ No		. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, of 1 ☐ Yes 2 ☒ No Specify:			1	14. Race - American Indian, Black, White, etc.		
	be filed within 72 hours after death with the Marylan at Hygiene. It all Hygiene. It is marked to the transmission of 28e of show other than material, or thanks of any and the marked at a search.	by Fu	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give							Specific		
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	within 72 ene. than "na!	plet	(Specify only highest grade completed) (Give kind of w Elementary/Secondary (0-12) College (1-4or 5+)				f work done during most of working						
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	be file tal Hy d oth evant	Be	17. Father's Name (First, Middle, Las	0)				18. Mother's Nar	me (First, Middle,	Maiden :	Sumame)		
		To	Frank Brown						ie Brown				
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship Richard Nalley /	(Type, Print) Spouse	-	ng Address (Street and Number or Rural Route Number) 7 Health Center Dr. Bow			ie, MD. 20716				
	1 an 1eal 3m 2		20a. Method of Disposition		b. Place of Disp	osition (N	lame of	- !	-	<u> </u>	cation - City or		
	permit. Pages Department of I Important: If ite any injury or of once.		1 N Burial 2 □ Cremation 3 l '4 □ Donation 5 □ Other (Spec	☐Removal from State	cemetery, cre	-			6/2006 1	gran	+1.7003	MD	
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	5 3		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the d y one cause on each line.	eath. Do not er	nter the m	ode of dying	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between	
E	Physician		Immediate Cause (Final disease or condition	Cardiac Arrythmia									
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):  Due to (or as a consequence of):									
		-	Sequentially list conditions,										
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
'n	be executed ician and burial-transit		that initiated events resulting in death) Last	C									
9	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal	d.										
200	ntifica ing ph s as th	Med	IF FEMALE:										
X Q Q	ath ce ttendi or use	Physiclan/Med	23b. Was decedent pregnant in the past 12 reoriths?  1						23d. Date of delivery Month Day Year				
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	that ted by	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did to	bacco us	cco use contribute to the cause of death?			
	quires n sign ald be	d by	Failure to thrive						1 🗆 Y	Yes 2 No 3 Probably 4 □Unknown			
Kecords	s bee	oleted							24a. Was a		24b. Were au	itopsy findings available	
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sion of Vital	lysician: is certifica director, p	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only or	<del></del>			
	Physician: this certific ral director,	2	1 Yes 2 No			nt 3□ DOA Other: 4 Nursing H		Home 5 Residence 6 Other (			cify)		
	19 19 19 19 19 19 19 19 19 19 19 19 19 1	lon:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?			?	28d. Describe how injury occurred					
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2	To the Hospital or Atta within 24 hours after de To tha Funaral Directo completely filled in by th	Certification:	4 Homicide determined determined building, etc. (Specify)					City or Town, State)					
	ospita hours inara y fille	alc	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									stated.	
	he Ho in 24 ha Fu	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								to the cause(s)		
	Vith To t	Σ	29b. Signature and kitle of certifier 29c. License								Date signed (Month, Day, Year)		
									Marc	ch 13,	2006		
)	(5)		30. Nameland address of person who				anit-	<b>ДЭЭТ В</b>	nan-14-	NAT-			
	Sta	ite.	31. Date filed (Month, Day, Year)	Chopra 600 Ri	gnature /	ve.	surte	#431 An	naports_	, MD			
	Registr		MAR 1 5 2006	32. Registrar's S	- Aces	(I)							

			1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg: No. 0 9 7 1 6								9716	
6)	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Year	3. Time of Death	
	/Medic		Opal Helen Nave				1	march		2000	1205 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Washington County Hospital  Hagerstown					4c. County of Death Washington				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday					8. Date of Birth		9 Birthplace (State or For		
	Director		214-32-4213	M 2 <b>K</b> ] F 72	Yrs.	Months Days	HOUIS MIII.	Oct. 9,	1933	Mary	l'and	
ore, Mar	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limits	
	Manyli 1 sho	ō	W. Virginia Berke	lev Fa	lling	Waters					1 ☐ Yes 2 No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Coun	itry?	
	th with	al D	169 Grade Road			25419		USA				
	r dea	Funeral	The state of the s	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ice - Americ ack, White,		
	or h	by Fi	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Speci	<sup>ify:</sup> Whi	<b>+</b> e	
	2 hours	led t	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of E			
	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired,	luring most of wo	i				
	ygien yerth t, tre	Con	12	0	Se	amstress					nufacturer	
	ed its b	Be	17. Father's Name (First, Middle, Last) William Reed					me (First, Middle, M Younker	alden Suma	me)		
	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, it a Madical Examinar must be notified at	ဥ	19a. Informant's Name/Relationship (Type	ng Address (Street a		ural Route Number,	City or Town	n. State. Zip	Code)			
	ges 1 and 2 should if of Health and Mer if Item 27 is marke or other traumatic		Norval Hull (Son)	,				Waters,				
	of Hea of Hea f Item r othe		20a. Method of Disposition	1 ~	lace of Dispo	osition (Name of matory or other place			Oc. Location			
	Page nenf c ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		rkhead	Cemetery	3-16	5-06 C	lear :	Spring	, Maryland	
	permit. Page Department Important: if any injury of		21. Schalure / Funeral School Licens	Θ	ď	Name and Address SDOFNE Fu	neral Ho	ome P.A. 4	25 Soi	uth Co	onococheague	
	705 # g		23a. Pany Enter the disease, or compli					Maryland			Approximate	
Popular	Physician /Medical Examiner		23a. Park Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		- faile			J.,		Interval Between Onset and Death Ticke k	
	cate be executed by sician and the burial-transit	Examiner	S-cuentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	a consequence of).							
98760	cate be physicians the buri	licai										
Division of Vital Records, P.O. Box 6	ne death certific the attending p thed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)					23d. Date of d Month		ory Day Year	
	juires that fhe de n signed by the a ild be detached f	b	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont							tribute to the cause of death?  3 Probably 4 Unknown		
	The law requir ate has been si page 2 should	Completed						24a. Was an autopsy perform 1 Yes 2	ed?	. Were auto prior to con death?	psy findings available mpletion of cause of	
	olan: artifica octor, I	Be	25. Was case referred to medical examiner?				26. Place of De	ath Check only one	o)			
5	hysio this co al dire	2	1 ☐ Yes 2 ☑ No			nt 3 DOA Othe	4 LI Nul Sing I	g Home 5 Residence 6 Other (Specify)				
Division o	Sing F	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	/at <br Yes 2 □No	28d. Describe ho	w injury occu	irred		
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical C										
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								Day, Year)	
			Michael J. Milowach MD D41667						3.14.06			
			30. Name and address of person who co		n 23a) (Type,	Print)	3555	yes 10	,			
4	1-4		Michael D. 1 31. Date filed (Month, Day, Year)	Melorneck 32. Registrar's Signa	1111	o Medi	cal (no	mus 10	17610	hun	MO	
	Sta Regist	ate rar	MAR 1 8 2	32. Hegistrar's Signa	M. A	harles						

Physician /Medical Examiner of partition of	Registrar  Decedent's Name (First, Middle, La.  Minnie Madeline  a. Facility Name (If not institution, giv.  Northampton Mano  Social Security Number  6. St. 19-20-2166  July State 10b. County  Laryland Frederic  10e. Street and Number  200 E 16th Street  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E.  (Specify only highest grave Street Street)  Remember 17. Father's Name (First, Middle, Last, Howard Nichole)	Null restreet and number  Sex 1 M 2 FF  7.  12. Was Deceded Armed Forc 1 Yes, Give Year or Date ducation	Age (In yrs. last bite 89 10c. City, Tow Frede) ent Ever in U.S. es?	yrs. If Mo	10f. Zip Code <b>21701</b>	rick		4c. Cour Free th, Year) 1916	nty of Death ederick  9. Birthplace (S Country) Thurmont	one of Death  Oh.  State or Foreign  Mary1  Side City Limits  Yes 2 \[ \] No
/Medical Examiner and marked other than "natural", or items 23s or 28s-f show it filters 27 is marked other than "natural", or items 23s or 28s-f show it filters 27 is marked other than "natural", or items 23s or 28s-f show it filters 27 is marked other than "natural" it is mar	a. Facility Name (If not institution, given Northampton Mano  Social Security Number 6. St. 19-20-2166  Joual Residence of Decedent  Oa. State 10b. County  Laryland Frederic  Oe. Street and Number  200 E 16th Street  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E. (Specify only highest grade)  Elementary/Secondary (0-12)  7  7. Father's Name (First, Middle, Last,	te street and numb  T  Sex  1	Age (In yrs. last bite 89 10c. City, Tow Frede) ent Ever in U.S. es?	yrs. If Mo	Frede f Under 1 Year fonths Days ion 10f. Zip Code 21701	rick	March Seath	4c. Cour Fre th, Year) 1916	9. Birthplace (S Country) Thurmont	State or Foreign Mary1
Fixaminer and mental hyperies of filem 27 is marked other than "natural", or itema 23s or 28s-f ahow red other than "natural", or itema 23s or 28s-f ahow red other than marked other than "natural", or itema 23s or 28s-f ahow red other than "natural", or itema 23s or 28s-f ahow red other than "natural" and "na	Northampton Mano Social Security Number 19-20-2166  Joual Residence of Decedent Oa. State 10b. County  Jaryland Frederic Oe. Street and Number 200 E 16th Street  1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra  Elementary/Secondary (0-12) 7 Father's Name (First, Middle, Last,	Sex 7.  1 M 2 P F 7.  12. Was Deced Armed Forc 1 Pes 2 If Yes, Give Year or Date ducation ade completed)	Age (In yrs. last bite 89 10c. City, Tow Frede) ent Ever in U.S. es?	yrs. If Mo	Frede f Under 1 Year fonths Days ion 10f. Zip Code 21701	rick	lrs. 8. Date of Bir	Fre	9. Birthplace (Scountry) Thurmont	, Mary1
Titlen 27 is marked other than "natural", or itama 23a or 28a-f ahow red other than "natural", or itama 23a or 28a-f ahow red other traumatic avant, the Medical Examinar must be notified at 10 to the Completed by Funerai Director 10 Be Completed	Jual Residence of Decedent  Oa. State  Juant Residence of Decedent  Oa. State  Jub. County  Iaryland  Frederic  Oe. Street and Number  200 E 16th Street  1. Marital Status  1 Never Married  Judy Married  Widowed 4 Divorced  15. Decedent's Encypeity only highest grade  Elementary/Secondary (0-12)  7  Father's Name (First, Middle, Last,	t  12. Was Decedd Armed Forc 1	10c. City, Tow Freder  ent Ever in U.S. es? Ones:	Yrs. Moreover or Location or L	ion  10f. Zip Code  21701		in. (Month, Da	1916	Thurmont  10d. Ins	, Mary1
filter 27 is marked other than "natural", or itema 23s or 28s-f show or other traumatic event, the Medical Exeminer must be notified at 10 for Completed by Funeral Director	Oa. State  10b. County  Iaryland Frederic  Oe. Street and Number  200 E 16th Street  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0·12)  7  7. Father's Name (First, Middle, Last,	12. Was Deced Armed Forc 1 □ Yes 2 If Yes, Give Year or Date ducation ade completed)	Freder	rick	10f. Zip Code <b>21701</b>			10g. Citizen	1 (	
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fitam 27 ia marke			for 5+)	(Give kind life. DO l	t's Usual Occupa d of work done d NOT use retired)	ation furing most of	working		f Business/Industry	
fitam 27 ia marke	HOWATA NICHA			amstre	ess		Name (First, Middle ha Floren	, Maiden Surr		У
ortant: if item 27 is injury or other trains 27 is 27	19a. Informant's Name/Relationship (			b. Mailing A	Address (Street a				wn, State, Zip Code)	21708
ortant: if itam injury or other	Betty Reed - Nied	ce							Woodsboro	
ortant: injury	t0a. Methed of Disposition		ate	ery, cremato	ory or other place	· 1	Date		on - City or Town, St	
	4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Liber		Blue I		Cemeter ame and Addres		3-2006 Stauffer		nt, Maryl 1 Home	and
	Alarow (U) 23a. Part 1. Enter the disease, or com	nelle	Eleve	162	1 Opossu	ımtown	Pike, Fre	derick	, Marylan	d 2170
ician and burial-transit and Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	r as a consequence	of).						
for use as	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live birt	ome of pregnancy h 2 ∐Fetal death nt at time of death vn		ctopic pregnancy ther (specify)				Date of delivery Month Day	Year
6 P P P	Part II. Other significant conditions of	contributing to dea	th but not resulting	in the under	orlying cause give	en in Part I.	23e. Did	1	ontribute to the cause 3 Probably	
page 2	//						24a. Was auto perfe 1 \( \text{Yes}		b. Were autopsy fin prior to completic death? 1 \( \text{Yes} \) Yes \( 2 \text{N} \)	on of cause of
the funeral d the funeral d ication: To	25. Was case referred to medical examiner? 1	28a. Date of (Month)	patient 2 ER/O Injury Day Year)  Injury - At home, f. g., etc. (Specify)	Time of Injury		er: 4 Nursin	Death (Check only g Home 5 Res 28d. Describe 28f. Location ( City or To	dence 6 de how injury oc		e Number,
Funer icai	(Check only 2 Medical Example 1997)	miner: On the bas							manner as stated. ce, and due to the ca	ause(s)
To the the transfer of the tra	29b. Signature and title of certifier  30. Name and address of person who	and manne	and the	(Type Prin	29c. License		3	-	gned (Month, Day, Y h 10, T ederick	
	31. Date filed (Month, Day, Year)	cookte	G 36 Distrar's Signature	00 1	West	1 gth	Strep	+ Fre	ederick	- , m

			1 - State Registrar	State of Maryland		artment of H			ene 2006	09718
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Petro Odarchenko	1				2. Date of Death Month March 1	Day Year	3. Time of Death
	Examir Funeral	ier	4a. Facility Name (If not institution, give s  7601 Wildwood Dr  5. Social Security Number 6. Sex	treet and number)  7. Age (In yrs. la	ast birthday)	Takoma If Under 1 Year	II Under 24 Hrs.	8. Date of Birth	4c. County of Death  Montgo  9. Birth	merv
	Director		076-26-7098 Usual Residence of Decedent	M 2□F 10	2 Yrs.	Months Days	Hours Min.	Month, Day, Aug 20,		place (State or Foreign intry) aine
	the Marylan 28a-f show	Director	10a. State         10b. County           Maryland         Montgome           10e. Street and Number		koma F			10	g. Citizen of What Co.	10d. Inside City Limits 1  Yes 2 □ No
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show programs to the traumatic event, the Medical Examinar must be positive appres.	by Funerai	7601 Wildwood Dr  11. Marital Status	2. Was Decedent Ever in U.s Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	20912 Vas Decedent of Hi Yes, specify Cuba	Specify:		USA  14. Race - Amer Black, White	ican Indian,
1215-	vithin 72 t ne. han "nati s Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give : life. [	lent's Usual Occupa kind of work done o OO NOT use retired	during most of wor	king	6b. Kind of Business/li	ndustry
and 5.	2 should be filed wand Mental Hygies is marked other tannatic event, in	Be	17. Father's Name (First, Middle, Last)	5+	P	rofessor		ne (First, Middle, M	Colle aiden Sumame)	ge
Mary	12 should I h and Meni 7 is marked traumatic	To	Vasyl Odarchenko  19a. Informant's Name/Relationship (Typ				and Number or Ru		City or Town, State, Zi	p Code)
Baltimore, Maryland 21215-0036	Pages 1 and 3 nent of Health Int: If Item 27 ury or other tri		Alexander Odarchen  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State 20b. Pl	ace of Dispos metery, crem	sition (Name of atory or other place	θ)	Date 20	MD 20912 0c. Location - City or T	
Balti	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service License	Samell	22	. Name and Addres	s of Facility Hi	nes-Rinal	06 S. Bound di Funeral lver Sprin	dbrook, NJ Home g, MD 20904
8/60,	American be executed hysician and hysician and hysician and hysician site between the principle of the princ	dicai Examiner	23a. Part1. Enter the disease, or emplic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ardial ence of): estive ence of): monia	Infarct:	Lon	or respiratory arres	st,	Approximate Interval Between Onset and Death
O. Box 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	déath 3□	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
rds, P.	as the	þ	Part II. Dther significant conditions cont Cerebrovascular Acc			derlying cause give			cco use contribute to t	
Vital Records,	The law ate has b page 2 sl	Completed	Hypertension Hypothyroidism					24a. Was an autopsy performe	ed? death?	opsy findings available ompletion of cause of
or VII	> 00	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 □ DOA Othe		th <i>(Check only one)</i> ome 50 Residen	ce 6  ☐Other (Speci	fy)
DIVISION	ding h. After fune	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury		at ? /es 2 □ No	28d. Describe how	injury occurred	
2	F = F -		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town,		
	To the Hospital or within 24 hours effe To the Funeral Discompletely filled in	Medical		cian: To the best of my know er: On the basis of examination and manner stated.						
	1D	~	29b. Signature and title of certifier	SEAN S S	AEDI	29c. License	60350	3/1	1. Date signed (Month, 13/06 (March	Day, Year) 13, 2006)
			30. Name and address of person who com	selection of the state of the s	23a) (Type, F Yew Ma	mpshire	Ave, Sui	te 305, Si	Iver Spring.	MD 20904
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 14	32. Redistrar's Signatu	THE A	more				

		For State Registrar		State of	Marylan		artment rtificate			and M	lental Hy	Reg. No.	106	09719	
Physici	an	1. Decedent's Name (First, MEleanor	fiddle, Last) <b>H</b> •	Pax	ton						2. Date of De Month <b>March</b>		2006 Year	3. Time of Death 4:15 PM	
/Medic Examir		4a. Facility Name (If not insti					4b. City,	Town, or	Location of	of Death			County of Deat		
LXuiiii		2006 Roanoke	Str	eet			Hyat						ince Ge		
Funeral Director		5. Social Security Number 218-54-5581		M 2 F 7	Age (In yrs. 96	last birthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bir (Month, D) 10/13/	1909	Co	thplace (State or Foreign punity) edict, MD	
Maryland a-f show	tor	Usual Residence of Deceder  10a. State 10b. Co	unty	orge's		y. Town or Lo								10d. Inside City Limits  ¥☐ Yes 2 ☐ No	
with the	Direc	10e. Street and Number 2011 Roanoke	ctro	a t			10f. Zip	Code 782				•	en of What Co	•	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. It of Heatth and Mental Hygiene. or other traumatic event, It at Marylan Extrainer must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2	Married	I2. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dat	es? √No X			ent of Hi	spanic Ori n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or No Rican, etc.)	p- 1	4. Race - Ame Black, Whit	erican Indian,	
od within 72 hours afl giene. er than "natural", or i, tre Medical Extend	Completed	(Specify only fine Elementary/Secondary (0-	<del></del>	cation completed) College (1-4	lor 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	during most	t of work	ing		nd of Business	Andustry	
iled wi Hygien ther th	Con	12 17. Father's Name (First, Min	idle. Last)			Home	maker		18. Mothe	r's Name	e (First, Middle		nestic Sumame)		
should be fand Mental Hard Mental Hard Mental Hard of umatic even	To Be	William Har								Johi			<b>,</b>		
and 2 should be file ealth and Mental Hy n 27 is marked oth her traumatic event		19a. Informant's Name/Rela Ann Harding (	, , , , ,		ghter)								Town, State, 20		
Pages 1 all nent of Hea int: If item ury or othe		20a. Method of Disposition 1 X Burial 2 Crema		emoval from St	ata   0	Place of Disponentery, createry, createry, createry	natory or o	ther plac			Date / 2006		cation - City or		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, ILE Magnes.		`4 □ Donation 5 □ Oth 21. Signature of Funeral Se		no -	-	22	2. Name an	d Addres	s of Facilit	y For	rt Linc	oln I	Funeral	Home	
certificate be executed / Americal Examiner continuer co	dical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	(	Respi Due to (o Metab	ratory ras a conseq colic E	uence of): Encepha uence or):		thy						Interval Between Onset and Death	
death certifi e attending   ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	II.		th 2 □Fete ntattime of d	death 3	□Ectopic pr □ Other (sp				23d. Date Mon			of delivery n Day Year	
sician: The law requires that the certificate has been signed by th rector, page 2 should be detach	Completed by PF	Part II. Other significant co		ntributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I					o the cause of death? robably 4 □Unknown	
e law rec has bee je 2 shou	plete	Hyponatremia	ı								24a. Was	DSV	24b. Were at	utopsy findings available completion of cause of	
The transfate has page	Com	Anemia									perf 1 ☐ Yes	ormed? 2X No	death?	2 □ No	
ing Phy L. After this funeral d	To Be	2 Accident in	ending vestigation	fospital: 1  ln ln 28a. Date of (Month		ER/Outpatier 28b. Time o Injury		8c. Injun Worl	er: 4 🗆 Nu	ırsing Ho	h (Check only ome 5 Res 28d. Describe	idence 6		entySans Reside	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification:	4 ☐ Homicide d	ould not be etermined	buildin	of Injury - At h	fy) 					City or To	iwn, State)		ural Route Number,	
Hospital 24 hours: 9 Funeral etely filled	dical	29a, Certifier (Check only one)	tifying Physicel Exemi	sician: To the t ner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin , in my o	ne, date an pinion, dea	id place, ith occur	and due to the red at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)	
To the within To the comple	Med		ertifier	1 1 1	^ /		290		e number	1 /-			11/2006		
(6)		30. Name and address of po		ompleted cause .06 Irvi	of death (Iter	n 23a) (Type.	Prim() J # 41				, DC 20				
		George C. A			gistrar's Signa						,				

		-	For	epartment of Health and Certificate of Death		ene 1006 09720
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physicia		Rhodia Montaque Perry		March 3,	2006 8:45p M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of D	eath	4c. County of Death
			Pineview Nursing Home	Clinton		Prince George
I	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 89 Y	day) If Under 1 Year If Under 24 Months Days Hours N	Min. 8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) North Carolina
	P.		Usual Residence of Decedent	and anothing		10d. Inside City Limits
	arylai show	_	10a. State 10b. County 10c. City, Town			1 ∑ Yes 2 □ No
	8a-f	Directo	Maryland Prince George Forestv		100	Citizen of What Country?
	with ti		1006. Naniam Drive	10f. Zip Code		
	s 23	sra	1906 Napier Drive  11 Marital Status 12. Was Decedent Ever in U.S.	20747		nited States  14. Race - American Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. It item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Middel Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No If Yes, Give  1 Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P</li> <li>1 ☐ Yes 2 X No Specify:</li> </ol>	uerto Rican, etc.)	Black, White, etc.  Specify:
Ö	hour turat			Decedent's Usual Occupation	16	Black  Sb. Kind of Business/Industry
Maryland 21215-0036	in 72 "na" r	Completed	(Specify only highest grade completed)	Give kind of work done during most of life. DO NOT use retired)	working	,
2	lene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 6th	Cook		DC Government
Ö	Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First, Middle, Ma	
<u>a</u>	ald be henta rked ric ev	To B	Cephus W. Montaque	Lillie	e Ferrell	
ary	s ma	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number o	or Rural Route Number, (	City or Town, State, Zip Code)
Σ	and 2 naith a 127 i			06 Napier Dr. Fore		
ore	of He of He ritem roth		20a. Method of Disposition  20b. Place of logometery  20b. Place of logometery	Disposition (Name of c, crematory or other place)	Date 20	Oc. Location - City or Town, State
Ĕ	Pages nent of I ant: if its ury or o			h Hill Cemetery	3/10/06 Ra	aleigh, North Carolina
Baltimore,	permit. Page Department Important: tf any injury or once.		21. Signature of Funeral Service Licensee	Alexander 5. Pope		
	1167	1	23a. Part1 Enter the disease, or complications that caused the death. Do no shock or heart failure. List only the cause on each line.			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the control	MORIC CALINE	WASCULA	2 DOSA Enset and Death
E	Examiner			.,,-		
		Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):		
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c			1
Ö,	e exe ian ai urial-1		resulting in death) Last Due to (or as a consequence o	f):		
8760,	ate bu hysic the bu	dlcal	d			
9	as as	Med	IF FEMALE:			
Вох	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
<u>o</u>	0 0 0	yslc	1 ☐ Yes 2 📉 No 9 ☐ Unknown 9 ☐ Unknown	5 Uther (specify)		
۵.	The law requires that the tite has been signed by thoage 2 should be detache	P.	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ds,	signed be det				1 ☐ Yes	2 No 3 ☐ Probably 4 ☐ Unknown
Ö	w require been sign	Completed			24a. Was an	24b. Were autopsy findings available
3e	has has	m l			autopsy perform	orior to completion of cause of
a	n: Th ficate r, pa		25. Was case referred to medical	OC Pleas of	1 ☐ Yes 2	
Vital Record	Physician: The la rthis certificate has ral director, page 2	o Be	examiner?  1   Yes 2   No	Oth on		nce 6 Other (Specify)
of	Phy or this oral d	I	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at	28d. Describe how	
Division of	I or Attending Ph atter death. Director: After th I in by the funeral	at lo	1 Natural 5 Pending (Month, Day Year) In 2 Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No		
<u> </u>	Attendi r death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
á	tal or A	Certification:	→ Hornicide Building, etc. (Specify)		0.0, 0.7, 0.1,	,
	Hospi 4 hour Funer ely fill	edical (	29a. Certifier Certifying Physician: To the best of my knowledge, (Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and all or investigation, in my opinion, death	place, and due to the car occurred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	To To		1/18	D-180	45 1	MIN 9 7006
1	(7)		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)	10 14	11 2000
_	0/		30 Name and address of person who completed cause of death (Item 23a) (  10 15 05 500 1 00 0 0 0 0 0 0 0 0 0 0 0	0 000 408	LEWELL V	Utility ud. 2002
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 4 2006	alle		

Registrar DHMH 17 Rev 1/2001

State

32 Agistrar's Signature

MAR 2 9

2006

06-2007 B.K.S DANIEL L. PAULEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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U	y	1	-	6

>		/Medic Examir
	F D	uneral irector
	ter death with the Maryland	items 23s or 28e-f ehow instrinst be notified at

a

Director 10e. Street and Number 10f. Zip Code 21555 16303 Oldtown Road SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give \ Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No is 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. Ifem 27 is marked other than "naturel", or other traumatic event, It a Misdical Exami Baltimore, Maryland 21215-0036 Vietnam Completed by 3 ☐ Widowed 4 1 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) welder 17. Father's Name (First, Middle, Last) Be Clarence Pauley 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n eny injury or other traun sonce. friend Una Landis 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service Licens 22. Nam Straftpelli fülleral Home, PA Immediate Cause (Final disease or condition ircho Physician resulting in death) /Medical Due to (or as a consequence of): Examiner ale 40 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Other (specify) page 2 should be detached 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been certificate 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be Hospital: 1 

fnpatient 2 🗆 No 1 ☐Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a 29a, Certifier To the title of confife 29c. License number 29b. Signafüre O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOGA 12. 111 31. Date filed (Month, Day, Year) State

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Pauley Sr. Daniel 2240 P M <u>21, 2006</u> MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY OLDTOWN 16303 OLDTOWN ROAD 8. Date of Birth Month, Day, Year 943 ff Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F 236-62-9821 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany MD Oldtown 1 ☐ Yes 2x No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry Boeing Aircraft 18. Mother's Name (First, Middle, Maiden Sumame) Marie Fleck Pauley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16303 Oldtown Rd. SE Oldtown MD 21555 20c. Location - City or Town, State 3/27/2006 MD Flintstone 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Party. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. 23d. Date of defivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No autopsy performed? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) MARCH 22, 2006

PENN STREET, BALTIMORE, MARYLAND 21201

Registrar

2006 9

32. Registrar's Signatur

			For State Registrar		State of M		/ Depa		t of H	ealth a	and M			06	0977	23
	Physici	an	Decedent's Name (Firs     Owen		Pearrell							2. Date of De March	ath 13	2006	3. Time of 11:47	
	/Medic Examin		4a. Facility Name (If not in			)		4b. City,	Town, or	Location o	of Death		-	nty of Death		
			4101 Bucke						leric		O A Library		Fred	erick		
	Funeral Director		5. Social Security Number		X 2□F 7.A	ge (In yrs. las	t birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da			ace (State or try)	' Foreign
	ס		217-28-6432 Usual Residence of Dece 10a. State 10b.	dent		75 10c. City, 1	Four or L	action.				Dec 25	, 1930		1 and Od. Inside Cit	a Limite
	Maryla fed at	ror		rederic	:k		ville							,	1 ☐ Yes	
	3a or 28a	i Direc	10e. Street and Number 1112 Rosem	ont Dri	.ve			10f. Zip					10g. Citizen	of What Coun	try?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ite Modral Extinities in unal be indifficed at ADGE.	ed by Funeral Director	11. Marital Status  1 Never Married 2  3 🛣 Widowed 4 🗆		12. Was Deceden Armed Forces 1. Yes 2 If Yes, Give Year or Dates	?  No  950-19	54	Was Decedif Yes, special Yes	2≹ No	Specify:		cify Yes or No Rican, etc.)	Spe	Race - Americ Black, White, cify: Whit Business/Inc	e	
215	hin 72 a. an "na	Completed	(Specify on	y highest grad	e completed) College (1-4or		(Give	kind of wo	rk done a	luring mos	t of worki	ng	TOD. Tallo	003110334110	idatiy	
	led wit lygiene her tha	Соп	Elementary/Secondary				E1	ectri	ciar	18 Methe	r'a Nama	(First, Middle	U.S. G	overnm	ent	
land	id be fi ental H ked of	To Be	17. Father's Name (First, James Russ		rrell							Pauline		,		
Maryland	nd 2 shou lith and M 27 le mar r traumati	-	19a. Informant's Name/R Bonnie Pea:	elationship (T)	<sub>/рө, Print)</sub> Daughte	r	19b. Maili 5541	ng Address Doubs	(Street a	ad, A	or or Rura dams1	l Route Numb	er, City or Tot ID 2171	wn, State, Zip	Code)	9
Baltimore,	Pages 1 a nent of Hee nt; If Item iry or othe		20a. Method of Dispositio	nation 3 🗆 F		cem	etery, cre	osition (Name matory or o emeter	ther place		3/17,	/06	20c. Location	on - City or To sville		
Balti	permit. Departmit. Importa any inju		21. Signature of Funeral Barbara	Service Ligens A Will	iams	124	2:	2. Name an	d Addres			T Will			Home	
68760,	by Wedicale be executed by the attending physician and signed by the attending physician and be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying that initiated events resulting in death) Last	re. List only o	Due to (or a	line.	nce of):					5			Approximate Interval Betwo	veen
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iani	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal de	eath 3[	⊒Ectopic pr ⊒ Other <i>(sp</i>						Date of delive Month	*	'ear
	quires that in signed b uld be deta		Part II. Other significant	conditions co	ntributing to death	but not resulti	ng in the u	inderlying c	ause give	en in Part I			obacco use c Yes 2 🗆 No			
Records,		Completed										24a. Was auto perfo 1  Yes		death?	osy findings a appletion of ca 2 No	ivailable iuse of
Vital	Physician: this certific ral director.	Be	25. Was case referred to examiner?	-	Hospital:				Othe	26. Place	of Death	(Check only	one)	Gran	d Daug	hters
Division of	ding Phy h. After this funeral d	Certification; To	2 Accident	Pending investigation Could not be	28a. Date of In (Month, D		8b. Time o	M 2	Work	rat (? Yes 2 □	No	me 5 Resi				
Div	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ai Certi			building, e	etc. (Specify)	edge, deat	h occurred	at the tim			and due to the				
	the Ho in 24 t the Fu ipletely	Medical	one)		ner: On the basis and manners	of examination stated.	n and/or in				ith occurr	ed at the time,				
	with To Con	2	29b. Signature and title of	certifier	7	5.		290	. License			,		ned (Month,		
	10		30. Name and address of P. Gregory							deric			M 217		200	°C
	Sta Registi		31. Date filed (Month, Da		32. Regis	strar's Signatur	гө						32,			

DHMH 17 Rev 1/2001

ORIGINAL

				FOL	partment of Health and Mertificate of Death	lental Hyg		09724
	7		25	Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
		Physici		Tracy Lynn Palmer		March	Day Year	6 2230 M
		/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
				Upper Chesapeake Medical Center	Bel Air		Harf	ord
		Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthd.</i> 215-72-4889 1□ M 2₺ F 33 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day June 15	, 1972 9. Bir CC M	thplace (State or Foreign ountry) aryland
		and	1	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
		Aaryli Poho	5	Maryland Cecil	Perryville			1 ☑ Yes 2 ☐ No
		d within 72 hours after death with the Maryland Jiene. r then "natural", or Iteme 23a or 28a-f ehow Ita Medical Examinational be notified at	Director	10e. Street and Number	10f. Zip Code		0g. Citizen of What Co	ountry?
		with the or	<u></u>	18 Owen Court	21903		U.S.A	-
0		ne 23	era		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	encan Indian,
X		ther d	듄	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		Rican, etc.)	Black, Whit	e, etc.
7	33	urs a	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give   3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	White
223	21215-0036	2 ho	Completed by Funeral	15. Decedent's Education 16a. De	cedent's Usual Occupation	10.0	16b. Kind of Business	,
0	75	hin 7	pie	(Specify onfy highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ing	l. Jess Croud Associates.	
_	21	DEL	Ö	Twelve Years	Accountant		Elkton, Maryl	
90	b	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle,	Maiden Sumame)	
0	<u>a</u>		To	Anthony John Palmer, Sr.	R	loxie L.	Kennedy	
3	ar	s 1 and 2 should f Health and Men tem 27 te marke other traumatic	Ė	19a. Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and Number or Run	al Route Number	, City or Town, State,	Zip Code)
	Σ	1 and 2 Health em 27 I			Barnes Corner Road	, Rising	g Sun, Mary	yland 21911
3	ore		- 2	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  20b. Place of Dicemetery, 6	sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
	Ĕ				rris & Co.,Inc. 03/1	8/06	West Chester,	Pennsylvania
	Baltimore,	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lee A. Patterson &	Son Fur	eral Home	РΔ
1	Ω	30E 2 9		Jones M. Latterson or	Perrvville, Marvla	nd 2190	3-0766	1
1		¥.,		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
120		Physician	l V	Immediate Cause (Final disease or condition a DISSIMING LCC)	intravascular C	acular		Onset and Death
		/Medical		resulting in death)  Due to (or as a consequence of):	in the was conting of	- Zucey		17 Cmys
क्रज्यान		Examiner	ř.	Sequentially list conditions b.		V	1	V
S.	or \$8.	P = =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
2		cutec	Examiner	Cause (Disease or injury that initiated events c.				
8	o,	e exe	Ä	resulting in death) Last Due to (or as a consequence of):				
3	3760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the buriat-transit	Icai	d				
T.	99	ng ph ng ph as t	Med	IF FEMALE:				
17	õ	th ce tendi	an/l	23h Was decedent pregnant 23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy		23d. Date of de Month	livery Day Year
7	E	the at	sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		World	Day Teal
90	P.0	that the de ed by the detached	Phy	9 Unknown		OO- Dida-		- At
	Ś	w requires that been signed to should be det	Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the Scienderma Small bowel of	Skutm		bacco use contribute to	robably 4 Unknown
+	of Vital Record	pluoi	ted	Screenburning Straw more of	siragin		es 2₽Ño 3∏P	
_	Ö	e law has b je 2 st	pje			24a. Was a autops	24b. Were a prior to	utopsy findings available completion of cause of
-	<u>~</u>	The laste happage	TO.			1 Yes		2 □ No
2	ita	ysician: The is certificate director, pag	Be (	25. Was case reterred to medical examiner?	26. Place of Deat	h (Check only or	ne)	
	<u>&gt;</u>	Physical this call dire	P	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpa			ence 6 Other (Spe	icify)
	п	tending Ph leath. tor: After th the funeral	-CO	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe he	ow injury occurred	
(7	Sio	Attendi death. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No			
	Division	or Att	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S. City or Town	treet and Number or R n, State)	ural Route Number,
		urs a						
		Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Medical	29a. Certifier  (Check only one)  2 ☐ Medical Exeminer: On the basis of examination and/o and manner stated.				
		the the	Mec		29c. License number		9d. Date signed (Mon.	th, Day, Year)
		To with		AMD (I) M	7117117		Mark 14	2001
		10		30. Name and address of person who completed cause of death (Item 23a) (Ty	07/76>	/	(10) 11)	0006
		10		30. Name and address of person who completed cause of death (item 23a) (1)	nex Chena mali A.	in Rel	1 Air M	1 2/1/14
		Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	29c. License number  D47463  pe, Print)  per Chenapealu Ari	7000	, , , , , , , , , , , , , , , , , , , ,	01011
	4	Regist		MAR 1 5 2006 Blown & goals				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician BAXTER RORIE 9 2006 MARCH 5:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 □ F 244-34-1317 78 Yrs. Director 29 1927 NORTH CAROLINA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 5113 ADDISON ROAD 20743 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No BLACK Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC PRIVATE 12 should be filed w h and Mental Hygier 7 in marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROANA BROADWAY ANDREW RORIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 ia m any injury or other traum HARROD/DAUGHTER 2108 E. MARLBORO AVE. # 11 LANDOVER, MARYLAND 20743 MARY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/16/2006 RIVERDALE, MARYLAND RIVERDALE CREMATORY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signalule of Euneral 5 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscleratic Covancy Immediate Cause (Final) Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of). Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ed bluods 3 Probably 4 ₹ Unknown 2 No Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? Yes 22(No certificate 1 TYes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 Yes 2 □ No Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 32 DOA ည 1 Inpatient 2 ER/Outpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52326 3/9/06 30. Na e and address of person who come leted cause of death (Item 23a) (Type, Print)

JAMES K. LIGHTFOOT, JR. M.D. 7600 CARROLL AVENUE TAKOMA PARK, MARYLAND 32 Registrar's Signature-State we & sports Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 14, 2006 Ruby Peaire Raley 7:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 12, 1927 **Funeral**  Birthplace (State or Foreign Country) 578-40-9571 1□M 2₩F 79 Director Yrs Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelith and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Evertical must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland 1 ☐ Yes ŽXX No Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7601 Redwood Court 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√X No Specify: Specify: White 3XXWidowed 4 □Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Office Clerk 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude Sebastian Peaire 0 Esther Anne Breashears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Mangum / Sister 7601 Redwood Court Brandywine, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 03/28/2006 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature o Funeral Service, Licensee 6160 Oxon HillRoad Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINONIA /Medical Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed pete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 DEctopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 🙊 No : After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 東図 Nursing Home 5 日 Residence 6 日Other (Specify) Certification; To 1 ☐ Yes 2**√**XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XXVatural 5 Pending investigation within 24 hours efter death. To the Funeral Director: Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Medical 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Name and address no completed cause of death (Item 23a) (Type, Print) 12670 ald LineCenter Waldon alute 100

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 5 2006

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  CHOWN DUT CUTINGUM  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  THOMA PARK  Funeral Director  2. Date of Month  CS  Month  Solve Street and number)  5. Social Security Number  2. Date of Month  CS  Month  THOMA PARK  6. Sex  1. Month  Month  THOMA PARK  1. Month  Month  Month  Feb. 2	Day Year 10 2006 11:27 AM  4c. County of Death  MOM Comsey
Funeral  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  THOUMA PARK  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs. 8. Date of Months   Days   Hours   Min. (Months)	4c. County of Death  MUMOWAN  Birth Day, Year)  3, 1963  9. Birthplace (State or Foreign County)  Wash., DC
Funeral 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month.)	3, 1963  9. Birthplace (State or Foreign Country) Wash., DC
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,	3, 1963  9. Birthplace (State or Foreign Country) Wash., DC
15	10d Inside Challente
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	
ho di	1∭∑Yes 2 □ No
Maryland Prince George's Landover  106. Street and Number  107. Zip Code	10g. Citizen of What Country?
7003 Hawthorne St. 20785	United States
Total Control of the control of th	No- 14. Race - American Indian, Black, White, etc.
The state of the s	Specify: Black
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  11th  Warehouse Manager	16b. Kind of Business/Industry
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)	Design a tra
Note that the secondary (0-12)   College (1-4or 5+)   Warehouse Manager    11th   Warehouse Manager    17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)	Private (le, Maiden Surname)
Albert R. Robinson  Vicurt	is Stevens
Albert R. Robinson  Vicurt  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num  19d. Name of the street And Number or Rural Route Num  19d. Name of the street And Number or	
Vicurtis Robinson/Mother 2904 Arundel Rd., #4, Mt. F	-
20a. Method of Disposition    Comparison   C	20c. Location - City or Town, State
Comparing   Comp	Washington, DC t Funeral Home
21. Signature of Fineral Service Licensee 4001 Benning Rd., N.E	
23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.    Physician   Immediate cause (Final disease or condition resulting in death)	arrest, Approximate Interval Between Onset and Death
Examiner  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate hards for the indexty of that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	N
Per p	
We do not be seen and the seen	
23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. D  23e. D  23e. D  24e. W	d tobacco use contribute to the cause of death?  Yes 2 \( \sum \) No 3 \( \sum \) Probably 4 \( \frac{1}{12} \) Inknown
	topsy prior to completion of cause of death?
1  Yes 2  Was case referred to edicat examiner?  25. Was case referred to edicat examiner?  1  Yes 2  Was case referred to edicat examiner?  1  Yes 2  Was case referred to edicat examiner?	y one)
1   Yes 2   VNo   1   Inpatient 2   VR/Outpatient 3   DOA   VIII   A   Nursing Home 5   R	e how injury occurred
See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location City or	n (Street and Number or Rural Route Number, rown, State)
The standard of the standard o	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
and manner stated.  296. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
35427	3-10-2006
(2) Name and address of person who completed cause of death (Item 23a) (Type, Print)  760 Canall And Thrown A TARK MD JAMES TO	XDAM ND
State Registrar MAR 1 5 2006  Was a signature of the sign	

			For State	State of	f Marylan		artment of I		d Mental H	ygiene Reg. No.	Carried S	09728
	* 7	i,	Registrar     Decedent's Name (First, Middl)	ə, Last)			Timodio or		2. Date of D		000	3. Time of Death
п	Physicia		Karo1	Anne	Roge	rs			March	3 Day	2006	5:25 A M
170	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town,	or Location of D	eath	4c.	County of Death	
38		·	Southern Maryl	and Hospi	tal Cen	ter	Clinton			Pı	rince G	eorges
	Funeral Director		5. Social Security Number 227–92–9736	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Vin. (Month, L June	lirth Day, Year) 19,19	9. Birth Con Vir	nplace (State or Foreign untry) ginia
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or La	antina					10d. Inside City Limits
	anyla sho	5					Cation					1 ☐ Yes 2 No
	28a-f	ect	Virginia Fair  10e. Street and Number	fax	Fai	rfax	10f. Zip Code			10g Citiz	zen of What Co	untry?
	with Ba or	<u></u>	9710 Kingsbridg	o Dr #2			22031			USA		,
	me 2:	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or N		14. Race - Amer	
ဖ	or ite	Fur	1 Never Married 2 Mar	ned 1 ☐ Yes If Yes, Giv	2 <b>X</b> No		If Yes, specify Cut  1 ☐ Yes 2X No		uerto Hican, etc.)		Black, White	o, etc.
93	ural',	d by	3 Widowed 4 Divorced	Year or D			10100 242100	Specify.			Specify:	White
2	flied within 72 hours after death with the Maryland Hygiene. other than "natural", or Itama 23a or 28a-f show ant, the Medical Exemiliar must be motified at	Completed		t's Education st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. Kir	nd of Business/I	ndustry
12	withir ene. then	mc	Elementary/Secondary (0-12) 12	College (1	-4or 5+)		river	10)		Fair	fax Sch	ool District
0	filed Hygin Sther	ပိ	17. Father's Name (First, Middle,	Last)		Dus D	LIVEL	18. Mother's	Name (First, Midd	le, Maiden :	Sumame)	
a	lid be lental ked c	To Be	Karl Olsen					Ruth	Huey			
ary	shou s ma uma		19a. Informant's Name/Relations	hip (Type, Print)		4			r Rural Route Num	-		
Σ	and 2 valith a n 27 i		Ruth Adkins/Mot	:her			0	0	, #2, Fa	irfax	, Va. 2	2031
altimore, Maryland 21215-0036	of He		20a. Method of Disposition 1 □ Burial 2 ☆ Cremation	3 □ Bemoval from	State 20b. P	lace of Dispo emetery, crei	osition (Name of matory or other pla	ice) Mo	Date		cation - City or	
Ĕ	Pag ment mant:		4 Donation 5 Other (S				tan Crem	atory	2006			Virginia
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be multiled at one.		21. Signature of Funeral Service	Licensee Taorald	,	22	2. Name and Addr Money & 171 W. M	ess of Facility KIng Fu [aple Av	neral Hove., Vien	me, I na, V	nc, a. 2218	0
			23a. Part1. Enter the disease, description shock, or heart failure. List	omplications that conty one cause on e	aused the death ach ine.	n. Do not ent	ter the mode of dy	ing, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	/Jepto	cemic	ί					Onset and Death
185	/Medical Examiner		resulting in death)	Due to (	(or as a consequ	uence of):						
	\$ \$ \$ \$ \$	-	Sequentially list conditions,	b. Due to l	or as a consequ	uence of:						
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	<b>4</b>	or as a conseque	perice or .					2.1	
	al-tra	Xar	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):						
8760,	ficate be executed physicien and is the burial-transit	dlcail		d.								
မ	tificat ng phy as th	led										
Box	Physician: The law requires that the death certific this certificate has been signed by the attending prat director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnanc	ev.		2	3d. Date of deli	
о. В	e dea he att	sicia	in the past 12 months? 1 Yes 2 No		ant at time of de		Other (specify)			-	Month	Day Year
<u>П</u>	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditi			ultinada thad	andarh (ing causa gr	uos is Bort I	22e Dio	1 tobacco u	so contribute to	the cause of death?
ds,	tw requires that s been signed t t should be det	ρ	End Stage ken	al Disease	Hein	oduly	sia Dea	endent				obably 4 Unknown
Ö	r requ	etec					1		_			
3eC	has l	Completed							24a. We aut	as an lopsy rformed?	prior to death?	topsy findings available completion of cause of
a	n: Th ficate or, pag		OF Was some referred to mading			- arres		00.01	1 ☐ Yes	2 ₽No	1 🗆 Yes	2 No
₹	sicia s certi irecto	o Be	25. Was case referred to medica examiner?  1 □ Yes 2 □ No	Hospital	Inpatient 2	ER/Outpaties	nt 3 DOA O	hor	Death <i>Check on</i> on the control of		C □Other (Spe	264
ō	g Phy er this eral d	n; To	27. Manner of Death	28a. Date	of Injury	28b. Time o			28d. Describ			му
<u>o</u>	ttending death. stor: Aft the fun	atio	1 Matural 5 ☐ Pendi 2 ☐ Accident invest	ig .	th, Day Year)	Injury		Yes 2 No				
Division of Vital Records, P.	after des Directo d in by th	Certification;	3 Suicide 6 Could 4 Homicide determ	uped 289 Place	of Injury - At hoing, etc. (Specify	ome, farm, st	reet, factory, office			(Street and own, State)		ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the Examiner: On the band man	best of my kno asis of examina ner stated.	tion and/or in	ivestigation, in my	opinion, death of	occurred at the time	e, date and	place, and due	to the cause(s)
	To th To th compl	Me	29b. Signature and title of certific	ır			29c. Licen	se number		29d. Date	e signed (Monti	n, Day, Year)
•	0		▶ Kah	~			0	0055121	0	Mar	3 rd 20	76
			30 Name and address of person	who completed cause	se of death (Item	n 23a) (Type,	Print) une SE.	Suite 31	0 Wal	ring how	DC 2	0032
	Sta Registr		31. Date filed (Month, Day, Year, MAR 1	4 2006	agistrar's Signa	iture	barle		O Wal			

			1 - For State Registrar	State o	of Marylar				lealth a Death		ental Hyg	iene	006	09729
	Physici	20	1. Decedent's Name (First, Middle, L	ast)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Mary E. Roderic								March	9, 2	2006	3:47 P
	Examir	ier	4a. Facility Name (If not institution, gr	ve street and nu	imber)				Location of	of Death			County of Death	
			1005 BALMORAL DRIVE 5. Social Security Number 6.	Sex	7. Age (In yrs.	last hirthday)		VER SP	RING	24 Hrs	8. Date of Birth		ONTGOMERY	place (State or Foreign
	Funeral Director		019-12-2106	1 ☐ M 2 ☑ F	89	Yrs.	Months		Hours	Min.	(Month, Day, AUGUST 13	Year)	Cou	ntry) MA
			Usuel Residence of Decedent							<u>_</u>	1100001 13	,		
	arylar show	<b>L</b>	10a. State 10b. County			ty, Town or Lo	cation							10d. Inside City Limits 1 □XYes 2 □ No
	38 -1 a	Director	FLORIDA SARASOT	A	5.	ARASOTA								
	with ti	Ē	10e. Street and Number				10f. Z	ip Code			1	0g. Citi	zen of What Cou	ntry?
	eath	Funerai	770 SOUTH PALM AVE		edent Ever in U	IS 13 1		4236_	isnanic Ori	nin? /Sne	cify Yes or No-		SA 14. Race - Ameri	can Indian
	filer d	E	1 Never Married 2 Married	Armed F	orces? 2 ⊡¥No		If Yes, sp	ecity Cuba	n, Mexican	, Puerto	Rican, etc.)		Bleck, White,	
3	al', o	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or [			1 ∐ Yes	2 🔀 No	Specify:				Specify: CAU	CASIAN
ဂ ဂ	72 hc	Completed	15. Decedent's I (Specify only highest g			16a. Dece			ation during mos	t of worki	na	16b. Ki	nd of Business/In	dustry
2	hen.	m jd	Elementary/Secondary (0-12)		1-4or 5+)			use retired	))			DIII	DITO EDUOA	MTON.
N	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itams 23e or 28e-f ahow event, the Medical Exertitive rotal by notified at		17. Father's Name (First, Middle, Las			EDU	CATOR		18 Mothe	er's Name	(First, Middle, I		BLIC EDUCA	ALION
Maryland 21215-0036	~ - 0 5	o Be	THOMAS F. HENRY	•,							V. SHERID			
<u></u>	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Mode.	오	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addre	s (Street					r Town, State, Zij	Code)
Ž	alth a		DR. ELLEN RODERICK	- DAUGHTEI	2	1005	BALMO	RAL DR	IVE; S	ILVER	SPRING M	209	903	
ē.	of He		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3			Place of Dispo cemetery, crer	sition (Nation)	ame of other plac	e)	C	ate	20c. Lo	cation - City or To	own, State
Ĕ	Pag ment		4 Donation 5 Other (Spec			. MARY'S	CEME	ΓERY	i	3/14/	2006	SALI	EM, MA	
Baltimore,	eparti nport ny Inj		21. Signature of Funeral Service Lice			22	2. Name a	and Addres	s of Facilit	y HI	NES-RINAL	OI FU	JNERAL HOM	Е
_	40 E 9 0		Myslin T. Kt										NG MD 2090	
			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	y one cause on	each line.		er the mo	ode of dyin	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	HEIMER'S									YEARS
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	300	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	quence of):								
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Ď,	e exe ien ar irial-t	Ë	resulting in death) Last	Due to	(or as a consec	quence of):								
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ROX	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	al death 3	Ectopic Other (	oregnancy				2	23d. Date of delive Month	ery Day Year
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2	res that igned b be deta	by Pt	Part II. Other significant conditions	contributing to	leath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did tot	acco u	se contribute to t	he cause of death?
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Ĭ	The lay ate has pege 2	Completed									perform	ned?	death? 1 ☐ Yes	
<u> </u>	cian: ertific actor,	Be	25. Was case referred to medical examiner?							of Death	(Check only on	ө)		
6	Physic this c	٩	1 ☐ Yes 2 ☐ No 27. Manner of Death			ER/Outpatier			4 🗆 140		me 5 ☐ Reside	nce 6	S¶Other (Special	PAUGHTER'S RESIDENCE
Division of Vital Records,	ding l	on	1 ☑Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	м	28c. Injun Worl	/at k? Yes 2.⊟i		28d. Describe ho	w injun	y occurred	
Š	deatictor:	fical	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Plac	e of Injury - At h	ome, farm, str			.03 2		28f. Location (St	reet and	d Number or Run	al Route Number.
S	after after I Dira	Certification:	4 Homicide	build	ling, etc. (Speci	fy)		,,			City or Town	, State,	)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2 Medical Ext	hysician: To the	e best of my kno	owledge, deatl	n occurre	d at the tin	ne, date an	d place, a	and due to the ca	ause(s)	and manner as s	stated.
	the hin 24 the f	Medical	one) 29b. Signature and title of certifier	and mar	ner stated.			9c. Licenso					e signed (Month,	
	5 ½ 5 º		250. Signature and title of certifier	/	l		1				-			ouy, real)
	40		30. Name and address of person who	completed so	se of death (fro	m 23a\ /Tues	Print)	D0983	-			3/ <b>T</b> (	0/2006	
	,				FARRAGU			CTON	MD 208	95				
7	Sta	te	31. Date filed (Month, Day, Year)	32. 1	gistrar's Sign	atura	PEACL	7.5.1						
	Registr	ar	MAR 14	2009	BARAR	10 11								

			For State		f Maryland						ental Hy	7111	16	09730
			Registrar Amend Item  1. Decedent's Name (First, Middle	#5 Per FI	<del>I C854 4/</del>	0370	rtificato	0, 2	- Cairr	1	2. Date of De	Reg No.		3. Time of Death
ı	Physici	an			D4 -1	1					Month	Day	2006	
	_/Medic		4a. Facility Name (If not institution		Richar	ason	4h City	Town or	Location of		March	4c. Cour		
	Examin	er											•	
_	Francis		Wilson Health C	6. Sex	7. Age (In yrs. las	t birthday)	If Under		rsbur If Under		8. Date of Bir	rth	tgon 9. Bi	irthplece (State or Foreign
	Funeral Director		<b>495</b> <del>459</del> –36–1749	1 ☐ M 2 🖾 F	88	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, <i>Year)</i> 22 <b>,</b> 1917		ountry) ouisiana
			Usual Residence of Decedent								White	1711	110	distana
	yland		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Mar Maria Mined	to	Maryland Montg	omerv	Ga	ither	sburg							1 X Yes 2 ☐ No
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5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "natural", or ltems 23a or 28a-f show event. The Medical Exatinizar must be mailfied at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		100	- 02 110	ороспу.			Зры	uny.	White
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Maryland	be first H dot	Be	17. Father's Name (First, Middle, I						18. MOTHE	ers Name		, Maiden Sum		
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<u>ā</u>	l 2 sh n and r Is n		19a. Informant's Name/Relationsh	,, ,				`				er, City or Tow		
	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury price other treumatic events.		Nada Poole/Frie	ena		A 1200 - 1110 -	Wells sition (Nan		kway		Lversit	-	•	. 20782 rr Town, State
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	tmen tent: tent:		'4 □Donation 5 □ Other (Sp		Brow		meter			200				Missouri
ga	ermit Depar npor ny in		21 Signature of Funeral Service I	N O	$\Omega(U_{i})$							eral H		
	003 e		23a. Part1. Enter the disease, or		war.								urg,	MD. 20877
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ř	The tav	mo	Limalia	Sense	01/19	and ,					auto perfe	ormed?/	death?	es 2 No
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Ö	g Phy er thi		27. Manner of Death	28a. Date	of Injury 2	8b. Time o		8c. Injury Work			-	how injury occ		,,
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Division of	or Attendate after death	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 280. Place	of Injury - At homing, etc. (Specify)	e, farm, st	reet, factory	r, office				(Street and Nui wn, State)	mber or F	Rural Route Number,
	To the Hospitel or Attending Physicien: Within 24 hours after death. To the Funerel Director: Atter this certifical completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the Examinar: On the b and man	e best of my knowle easis of examination ner stated.	edge, deat n and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and date and plac	manner a e, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	5	29b. Signature and title of certifier	,			290	. License	number			29d. Date sig	ned (Mor	nth, Day, Year)
			H. Raker	there	- leha -	lu	21.	000	4113	5		mar	ch	8,2006
	8		30. Name and address of person of LOBERT S  31. Date filed (Month, Day, Year)	who completed cause	se of death (Item 2	3a) (Type,	Print)	POLI	RU	322	LL A	VENUL	200	カーフ
	Sta	te	31. Date filed (Month, Day, Year)	32	legistrar's Signatur	θ			•					
	Registr	ar	MAR 14	2006	and to									

7			1 - For State Registrar	State of Ma	aryland /	Departm <i>Certific</i>			Mental Hy	giene ()	6 0	973	ада-интеревей
*	Physici	20	1. Decedent's Name (First, Middle, Last)						Date of De     Month	Day	Year	3. Time of	Death
	/Medic		Evelyn Sophie		1				Mar.	10, 2	2006	2:00	рм
P. L	Examin	er	4a. Facility Name (If not institution, give s  Anne Arundel Me		antan	4b. 0	•	Location of De			ty of Death		
klega,		< L	5. Social Security Number 6. Sex		encer e (In yrs. last bi	inthday) If Ur	AIIII nder 1 Year	apolis	rs Q Data of Bir	th.	O Diethe	runde	
	Funeral Director			M 2⊠F	90	Yrs. Mon	ths Days	Hours M	Jun. 2	, Year) 915	Cour	MD (MD	
	ם		Usual Residence of Decedent										
	Marylar a-f show	tor	MD 10b. County Anne Ar	undel	10c. City, Tov	wn or Location	A	rnold			1	0d. Inside Ci	
	or 284	Director	10e. Street and Number			10f	Zip Code			10g. Citizen of	f What Cour	ntry?	
	ath w	rail	976 Shore Acres R					21012			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show my injury or other traumatic event, Ite Medical Eracing must be notified at ances.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		į	ecedent of Hi specify Cuba is 2 X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Spec	ace - Americ lack, White, hify: Wh		
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grade		168	a. Decedent's (Give kind o	f work done d	furing most of v	vorking	16b, Kind of I	Business/In	dustry	
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)		ot use retired amstre			S	alf. F	mploye	a
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an	ld be ental ked o ic eve	To B	Spencer Cumming	s Jones				Lenoi	a Doroth	y Schae	effer		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Me	-	19a. Informant's Name/Relationship (Ty		19	b. Mailing Add	ress (Street a		Rural Route Numbe			Code)	-
	and 2 eaith a n 27 is		Joseph Repella/H	usband				res Roa	ad, Arnol	d, MD	21012		
more	Pages 1 nent of He int: If Iten iry or oth		20a, Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify)	emoval from State	cemete	of Disposition ery, crematory O Crema	or other plac	ө) М	ar. 13,	20c. Location Ba	n - City or To ltimor		
Balt	20a. Method of Disposition  1 Datial 2 XCremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy										rk Fu	neral :	Home
	4 44		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or								11.0	Approximate Interval Bet	9
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<u>α</u>	signed by	by	Part II. Other significant conditions con	tributing to death bi	ut not resulting	in the underlyi	ng cause give	en in Part I.		obacco use co		N	eath? Jnknown
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Il Records,	ding Physician: The lav h. After this certificete has funeral director, page 2:	Completed			- auto	psy proped? 25 No	prior to co death? 1 Yes	psy findings mpletion of c 2  No	ause of				
Vital	ician; sertific ector,	Be	25. Was case referred to medical examiner?	lospital:			Oth	25	Death (Check only o				
of	Physician: rthis certifice ral director, p	10	1 Yes 2 7 No	28a. Date of Injur		Outpatient 3	DOA Othe	4 🗀 Nursin	g Home 5 Resi			<b>'y</b> )	
on	ding h. After fune	tion	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury M	28c. Injun Work	k? Yes 2 □ No	254. 50001150	11011 111 011	4,104		
Division	f or Attending after death. Director: After I in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, to. (Specify)	farm, street, fa	ctory, office		28f. Location ( City or To		mber or Rura	al Route Num	ber,
	To the Hospitei or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physical Examination	sicien: To the best of the basis of and manner sta	examination a	ge, death occu und/or investiga	rred at the time	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and n date and place	manner as s e, and due to	tated. the cause(s	i)
	within To the	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date sign			
	- 3 PP 0		N X Z		-		D3	203	7	MNZ	2 10	, 20	06
			30. Name and address of person who co								· · · · · · · · · · · · · · · · · · ·		
	Sta	ato.	31. Date filed (Month, Day, Year)		ar's Signature	2001 Medi	cal Par	kway 7	Annapolis	MD 2140	)		
	Registi		MAR 1 4 2006		K	Shoulk	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elaina Stona 0930 M VIa MAPE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. KOAL 6 eoyes 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Days Min -32-219 1 M 2 2 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is markad other than "natural", or itams 23a or 28e-f show traumatic avant, that Medical Examinar must be multified at Prince Googe 1 ⊕ Yes 2 □ No Director Maryland orest 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or itams 23a any injury or other traumatic avant. It is Medical Evant writness once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) eaa Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Shor earlee Danie sranam Informant's Name/Relationship 19b. Mailing Address (Street and Number Jural Route Number, City or Town, State, Zip Code) 0 Spouse 2204 laurice Stylle MD 20743 20c. Location - City or Town, State ORUS 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State butus Mem. Park March 11,200 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Pape 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Homes ava 5538 Marlboro Forestville, Mb. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one earse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atheroscherotte Cardie VASCULON disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Examiner ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760 use as signed by the attending to be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tyes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown director, page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 - No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural Injury s after dea... al Diractor: Afr 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier npletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVAden 304 vester 5 . Registrar's Signature 31. Date filed (Month, Day, Year, State MAR 1 4 2006 Registrar

		•	For State Registrar	State of	Marylan		artment of H		nd Me		iene g. No. 00	6	097	33
Г	Physici	an	Decedent's Name (First, Middle		0-	la				2. Date of Death Month 1ar 22, 2		Year	3. Time (	
	/Medic	al	Ethel 4a. Facility Name (If not institution	Mae		hramn	4b. City, Town, or	Location of		iai ZZ, Z	4c. County	of Deeth		pm <sup>м</sup>
	Examin	ier	Cumberland Nu				Cumberl				Allega			
	Funeral Director		5. Social Security Number 218-40-3012	6. Sex 1 □ M 2 □ F	7. Age (In yrs. I 92	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8 Min.	Jun 22,	1913	9. Birth	place (State atry)	or Foreign
	faryland show	'n	Usual Residence of Decedent  10a. State 10b. County  MD Alleg	jany	10c. City	, Town or Lo	perland						10d. Inside 0	City Limits
	or 28a-	Funeral Director	10e. Street and Number				10f. Zip Code	04500		10	Og. Citizen of		ntry?	
	eath w	eral	25 Mary Street	12. Was Deced	tent Ever in II	S 13 V		21502	in? (Speci	fy Yes or No-	US 14 Bac	·	can Indian,	
98	filed within 72 hours after death with the Maryland Hygiene. Uther then "naturel", or Hems 23e or 28a-f show shift I're Madical Externitied at	by Fun	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Ford	ces? 2.√⊓No		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Specify:	Puerto Ri	can, etc.)	Blac	k, White,	etc.	
2	72 hou	ted	15. Decedent (Specify only highes	's Education		16a. Deced	dent's Usual Occup	ation	of working	,	16b. Kind of B			
2121	within i	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done of DO NOT use retired emaker	1)	or worning		Own Ho	me		
and	d be filed ental Hyg ced other c event,	To Be C	17. Father's Name (First, Middle, I Floyd Stickley							First, Middle, N				
Mary	d 2 should be f th and Mental I I? Is marked of treumatic eve	19a. Informant's Name/Relationship (Type, Print) Pauline Saville  19b. Mailing Address (Street and Number or F 25 Mary Street  25 Mary Street									City or Town, erland	State, Zi	MD 21	502
Baltimore, Maryland 21215-0036	Pages 1 an nent of Heal int: If item 2 iry or other	1	20a. Method of Disposition  1			emetery, crer	esition (Name of matory or other place norial Park	ce)	Dat 3/		20c. Location -			MD
Baltir	permit. P Departme Importen any injur:													
-			23a. Parti. Enter the disease, or shock or heart failure. List	complications that ca	used the death	n. Do not ent						21502	Approxima Interval Be	ite
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ce	rebro V	ias cul	A	ci du					Onset and	Death
	Examiner			Due to (d	ir as a consequ	ience oi).								
	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury	Due to (c	r as a consequ	uence of):								
v o	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a consequ	uence of):						-		
68760,	icate be physici s the bu	dlcal		d								-		
Box	ath certi	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 🗍 Fetal	death 3	Ectopic pregnancy	,				te of deliv		Year
o	D 0 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of de wn	atri 5	Other (specify)							
ds, P	uires that the de signed by the a lid be detached f		Part II. Other significant condition	ens contributing to dea	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.			acco use cont s 2 □ No	ribute to t 3 □ Prol	_	death?  Unknown
Division of Vital Records,	The law requires that the tee bas been signed by the bage 2 should be detache	Completed								24a. Was an autopsy perform	/ ned?	prior to co death?	opsy findings impletion of	available cause of
ta		0	25. Was case referred to medical					26. Place o	of Death (	1 ☐ Yes 2 Check only one	- <u> </u>	I □ Yes	2∐ No	
<u>&gt;</u>	Physicien: r this certificaral director,	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 □ In	patient 2	ER/Outpatien		er: 4 Nurs		5 Reside		er (Speci	(y)	
iono	ting Afte fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investig	9	f Injury , Day Year)	28b. Time of Injury	Wor	yat k? Yes 2.⊟No		d. Describe ho	w injury occur	red		
Divis	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	28e. Place of building	of Injury - At ho g, etc. (Specify	me, farm, str ')	eet, factory, office		28	f. Location (Str City or Town,	eet and Numb , State)	er or Run	al Route Nur	mber,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifyin 2 Medical (	g Physician: To the I Examiner: On the ba	sis of examinat	wledge, death tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and occurred	d due to the ca at the time, da	use(s) and ma ite and place,	inner as s and due t	stated. the cause(	s)
	To th withir To th compl	Me	29b. Signature and title of certifier	1 0			29c. Licens				d. Date signe			. /
<u>.</u>	,		<b>)</b>	- Justin				332	SU		Marc	2 24	1,200	6
	5		30. Name and address of person Sunil Gupta M		of death (Item		Print) Kent Aven	ue Cur	nberl	and MD	21502			
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 9 2		gistrar's Signa	ture	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item # 23a, 27, 28a-f. pen/IE 9853, 3730/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2006 Month **Physician** 9 March Rita Kav Seneca 5:32 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Easton Memorial Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Vest Virginia 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 M 2 F 1953 West 52 April Director 4. 214-60-7471 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ⊋Yes 2 ☐ No Director Denton Maryland Caroline the Modical Exactiner must be notified the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21629 United States of America 9 North Fifth Street Items 23a death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after ment of Heelth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examina 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) GED College (1-4or 5+) Home Homemaker 18, Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virginia Mae Richmond Emery Dow Lamaster ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 North Fifth Street, Denton, Maryland 21629 Joseph D. Seneca Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2006 Capitol Crematory Dover Delaware 22. Name and Address of Facility 21. Signatur of Funeral Service Littensee Moore Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate our Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bupropion intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No certificete 1 Yes : After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Injury unk 1 Natural 5 Pending within 24 hours effer death.

To the Funeral Director: Af 1 ☐ Yes 27 No investigation 3/3/2006 subject ingested drug 2 Accident 3 X Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9 North 5th St. Denton, MD To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sigg and title of certifier ature OCME and address of person who completed cause of death (Item 23a) Type, Print) J. LARON LOCKE, 111 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2006

DHMH 17 Rev 1/2001

Registrar

		1 - For State of Maryland / Department Certificate	e of Death	Reg. No.	1116 114/35
Physic /Med		Decedent's Name (First, Middle, Last)     Hildegard K. Silkoff	_ N	Date of Death Month Day ICh 22	2006 3. Time of Death 1:15 P M
Exami		Howard's House Assisted Living Tan	Town, or Location of Death  eytown  r 1 Year   If Under 24 Hrs.   8 D	Ca	county of Death arroll County
Funera Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Months  Usual Residence of Decedent	Days Hours Min. (/	Date of Birth Month, Day, Year) UNE 30 19	9. Birthplace (State or Foreign Country) Germany
Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location Maryland Carroll County Taneytown			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the 3s or 28s	Funeral Director	10e. Street and Number 10f. Zij 4949 Middleburg Road	21787		zen of What Country? ed States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other traumatic event. The Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes, spe 1 Yes 2 X No If Yes, spe 1 Yes or Dates:	dent of Hispanic Origin? (Specify cify Cuban, Mexican, Puerto Ricar 2K No Specify:	in, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ad within 72 hours aff giene. sr than "natural; or the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usu (Give kind of we life. DO NOT u	· ·		nd of Business/Industry  Ome Care
Maryland of the file of the and Mental Hygers is marked other traumatic event.	To Be C	17. Father's Name (First, Middle, Last) Kanonier Friedrich Gondermann	18. Mother's Name (First Anna Elisal		
Mary nd 2 shot alth and h 27 is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address  Joann Goldsbrough/personal rep. HC 62, Bo	s (Street and Number or Rural Room  X 34-M Great C		
Baltimore, permit. Pages 1 ar Department of Hear mportant: if Item any Injury or othermore.		20a. Method of Disposition  1  Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify)	other place) March ematorium 20	23, Sm:	cation - City or Town, State ithsburg, Maryland
Balt permit. Depart Import any Inl			nd Address of Facility Skile ast Baltimore St		l Home neytown, Md. 21787
ecords, P.O. Box 68760,  law requires that the death certificate be executed as been signed by the attending physicien end as been signed by the attending physicien end as should be detached for use as the burial-transit	Ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Socialized by the condition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		spiratory arrest,	Approximate Interval Between Onset and Death MGAHA
P.O. Box 68 hat the death certifica d by the attending ph	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1			23d. Date of delivery Month Day' Year
cords, P.O. I	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.		ise contribute to the cause of death?
The The page	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of Vital Re Physician: The rthis certificate ha ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 Do	26. Place of Death (Ch OA) Other: 4 Nursing Home	5 ☐ Residence	assisted
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	Work?  1 Yes 2 No	Describe flow injur	facility  d Number or Rural Route Number,
Div Hospital or / 24 hours after Funeral Dire tely filled in b	I Certi	4 Homicide determined building, etc. (Specify)  29a. Certifier Mark Certifying Physicien: To the best of my knowledge, death occurred		City or Town, State	
To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at	t the time, date and	d place, and due to the cause(s)
T S O		1 Rens K. Galun in	D3/660		2006
_5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thomas K. Galvin, M.D. 295 Stoner Aver	nue, Suite 203	Westmir	nster, Md. 21157
S Regis	tate trar	31. Date filed (Month, Day, Year)  MAR 2 9 2006			

			For State Registrar	State of Maryland		artment of H tificate of I		•	giene Reg. No.	06	9736
	Ψ.		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	Yeer	3. Time of Death
	Physici /Medic		GEORGE	SAT	TERWH.	ITE		MARCH	7.	2006	10:45 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat	h	4c. C	ounty of Death	
			700 Pritchard L			Upper Ma	rlboro			nce Geo	
н	Funeral		5. Social Security Number 6. S	VTM 2□F	Vre	If Onder 1 Year  Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Cou	
	Director		249-48-5896 Usual Residence of Decedent	7:	2			April 3	, 193	3   Salu	ida, S.C.
	land ow	Ì	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Many Fed sh	to	Maryland Prince	Georges U	pper M	ar1boro					Yes 2 No
	r 283	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
	th with		700 Pritchard La	ne		20774			Unit	ed Stat	es
	deal	Funeral	11. Marital Status		S. 13.\	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	)- 14	Race - Ameri Black, White,	
9	or It	Y.F.	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1/20 1 Types 2 No 1/20 If Yes, Give Year or Dates: XOREA	4/24	I ☐ Yes 2 ☐ No	Specify:	•	1 _		.ack
8	urel',	d by	3 Widowed 4 Divorced	3/31/	00	lent's Usual Occup	nting		10h Vina	d of Business/In	duate
7	n 72	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	TOD. KING	O BUSINESS/III	dustry
7	withi lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	E1	ectriciar	i 1		Go	vernmen	t
D D	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nar	me (First, Middle	, Maiden S	'umame)	
<u>la</u>	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23e or 28a-f show other treumatic event, Ire Madical Examinating the rediffed.	To B	Willie Satterwhi	te			Rosa I	Bell Ebo			
Maryland 21215-0036	A DE E		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street	and Number or Ri	ural Route Numb	er, City or	Town, State, Zip	Code)
	and 2 salth n 27 i		Dorothy Satterwh		- Constitution of the Cons	ritchard	Lane Upp				0774
altimore,	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	TD Chata   C6	emetery, crer	sition (Name of natory or other place	9)	Date (1006		ation - City or T	
Ĕ	Pag ment ent: ury c		`4 □Donation 5 □ Other (Specif	(y) A.	rııngt	on Nation	iai 3/16	5/2006	Arlı	ngton,	va.
Balt	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre 20029.		21. Signature of Funeral Service Licer	1see		. Name and Addres Alexander 5538 Mari		Funera ke/Fores	1 Hom	es,P.A.	20747
	1.38		23a. Part1. Enter the disease, or com shock, heart failure. List only	plications that caused the death	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
1	Enysician		Immediate Cause (Final disease or condition	a LUNG CANCEL							Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ							
П	Examiner		Sequentially list conditions,	b							
	pe is	ılner	if any, leading to immediate cause. Enter Underlying Cause Jecutes of hours that initiated events	Due to (or as a consequ	uence of):						
_	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	cDue to (or as a consequ	uence of);						
8760,	be eg	al E		, , ,	,						
687		edical		_ d							
	certii nding use a	Ŋ.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		-			23	d. Date of deliv	ery
Вох	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physiclan/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)				Month	Day Year
Ö.	t the c	hys	9 Unknown	9□ Unknown							
٦,	es tha igned l	by P	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.				he cause of death?
Records,	w require been sig should b							1 🗆	Yes 2	No 3 ☐ Pro	pably 4 Nnknown
ecc	e law re has bei je 2 sho	Completed						24a. Was	psv	24b. Were auto	opsy findings available
		EO.						perfe 1 🗆 Yes	ormed? 2 A No	death?	mpletion of cause of
Vital	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only			
of \	Physicien: this certificand in director,	유	1 Yes 2 No		ER/Outpatier		er: 4 🗆 Nursing I				fy)
U C		lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
Sic	Attending r death. ector: Afte	icat	2 Accident investigation 3 Suicide 6 Could not be	9 28a Place of Injury - At ho	me farm str		163 2 110	28f. Location	Street and	Number or Run	al Route Number,
Division		Certification;	4  Homicide determined	building, etc. (Specify	y)	cot, radiory, orrice			wn, State)		
_	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in I		29a. Certifier 1 ▼ Certifying Pl	nysician: To the best of my kno miner: On the basis of examinat	wledge, deat	n occurred at the tin	ne, date and place	e, and due to the	cause(s) a	and manner as s	stated.
	ne Ho 1 24 h ne Fu sletely	edical	(Check only 2 ☐ Medical Examone)	miner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	urred at the time.	, date and p	place, and due t	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	7		29c. Licens				signed (Month,	
)			· unst	treenas			20459			14, 20	
P	- (6)		30. Name and address of person who ANTHONY G. ARCENA	completed cause of death (Item S, M.D., VA ME	n 23a) (Type, DICAL	CENTER 50	) IRVING	STREET	NW, W	<b>IASHIN</b> G	ON,DC 20422
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 5 200	Registrar's Signa	ture	B					
			1111 111 11 11 11		1						

		State Registrar	( a a a b	C	ertificate of L	<i>Death</i>	Reg	No.	107
hysicia	an	<ol> <li>Decedent's Name (First, Middle, Ruth</li> </ol>					2. Date of Death Month	Day Year	3. Time of Death
/Medic	al -	4a. Facility Name (If not institution,	Stones		45 City Town	Landing of Dooth	March 10		9:30 P
xamin	er	2202 Montgomer			Silver	Location of Death		4c. County of Dear	gomery
100			-	(In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth		
ineral ector		056-38-5281	1 ☐ M 2 🔀 F	99 Yrs.	Months Days	Hours Min.	April 7,	1906 Nor	thplace (State or Fore cuntry) th Carolin
		Usual Residence of Decedent							
how E		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Lim
19-1	cto	Maryland Mo	ontgomery	Silver	Spring				1   Yes 2
Important: If Item 27 is marked other than "natural", or Itema 23a or 28e-1 ehow any injuryor other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number			10f. Zip Code		109	. Citizen of What Co	ountry?
23a	la	2202 Montgomer	ry Street		20910			USA	
E E	Jue	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 1	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
10,0	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give	lo	1 ☐ Yes 2 № No	Specify:		Specify: Whi	te
al Ex	d b		Year or Dates:	160 00	andont's Heyel Ossues	ation	1.0	h Kind of Dunings	And to the
Da C	Completed	15. Decedent' (Specify only highest	t grade completed)	(Gi	cedent's Usual Occupa ve kind of work done o . DO NOT use retired	during most of work	king	b. Kind of Business	industry
the M	E	Elementary/Secondary (0-12)	Coflege (1-4or 5	+)	omemaker	,		Own Hom	ie
office ant, 1		17. Father's Name (First, Middle, L	.ast)			18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	
9A 9 3	o Be	George E. Long	a .			Flora G	oodman		
mari	ဥ	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	uling Address (Street a	and Number or Rui	ral Route Number, C	ity or Town, State.	Zip Code)
27 is		Mary S. Tobin,		220	2 Montgome	rv Stree	t. Silver	Spring.	MD 20910
THE S		20a. Method of Disposition	Daugneer		position (Name of rematory or other place			c. Location - City or	
		1 StBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			rematory or other plac eaven Cemeter	TIGE	ch 15, S:	ilver Spr	ing, Mary
in ur.		21. Signature Pureral Service L				-	2006		
any in		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	D Cile		Francis Addes				a.MD 2090
		23a Part1 Enter the disease, or o	complications that caused	the death. Do not					Approximate
		23a. Part1. Enter the disease, or of shock, or heart failure. List of fmmediate Cause (Final)	9			g,			Interval Between Onset and Death
sician edical		disease or condition resulting in death)		lmonary A	rrest				
miner				a consequence of):					
			Aspiration	on Pneumo	nia				
	e.	Sequentially list conditions, if any, leading to immediate	b	on Pneumo	nia				
ansit	mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		nia				
n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a		nia				
sician and burial-transit	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	à consaquenta of).	nia				
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is certificate has been sign director, page 2 should be	Certification: To Be Completed by Physician/Medical Ex	## Presenting in death) Last  ## If FEMALE:  ## 23b. Was decedent pregnant in the past 12 months?  ## 12 months?  ## 10 Wes 2   No 9   Unknown  ## Unknown  ## 10 Unknown  ## 10 Unknown  ## 10 Unknown  ## 25 Was case referred to medical examiner?  ## 1   Yes 2   No    ## 12 Natural 5   Pending examiner?  ## 2   Accident   Investig    ## 3   Suicide 6   Could n determined.	b. Due to (or as a d. C. Due to (or as a d.	a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the  nt 2 ER/Outpat y Year) 28b. Time Injur	BDOA  Other (specify)  underlying cause give  ient 3 DOA  Oth  of 28c. Injury  Mort  M 1 1  street, factory, office	26. Place of Dea er: 4 ☐ Nursing H / at ?'es 2 ☐ No	24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how	Month  2 No 3 Pi  24b. Were at prior to death? 1 Yes  6 Other (Speinjury occurred	Day Year  o the cause of death?  robably 4 Minkno  utopsy findings availate completion of cause  s 2 No  exify)
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			State of Maryl		artment of He rtificate of D		lental Hygier Reg. t	71116	09738
ı	Physici		1. Decedent's Name (First, Middle, Last) Bert SILVERMAN				2. Date of Death Month 13,	<sup>0ay</sup> 2006 Year	3. Time of Death 3:45 AM M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Silver	Location of Death Spring		tc. County of Dea Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1	yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth  (Month, Day, Yea  Jan . 0, 1	9. Bit PA	thplace (State or Foreign ountry)
	e Maryland	ctor		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	th with th	al Director	10e. Street and Number 1121 University Blvd. West,	#410	10f. Zip Code 20902		10g. (	Citizen of What C USA	ountry?
920	n 72 hours after death with the Maryland "naturel", or itema 23e or 28e-f ehow idical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Pos 2 □ No The Was Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	spanic Origin? (Soon, Mexican, Puerto Specify:	ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
9500-6121	72	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired) nistrator	tion uring most of work	ing	Kind of Business	Administrat
yland 2	Id be filed within entail Hygisne. Ked other than ic event, Ins. M.	To Be Co	17. Father's Name (First, Middle, Last) Charles Silverman			18. Mother's Name unkno	e (First, Middle, Maid	en Sumame)	
Mar	es 1 and 2 should b of Health and Ment fitem 27 ie marked r other traumatic e	0.000	19a. Informant's Name/Relationship (Type, Print)  Tayba Dale, step daughter				al Route Number, Cit PO BOX 5		Zip Code) 20859
Baitimore,	permit. Pages 1 a Department of Hee Important: If item eny injury or othe			b. Place of Dispo cemetery, cren t. Leban	natory or other place	•)	20c. 15, 200.6	Location - City of Adelphi	
Dall	Departicular Depar		21. Signature of Fun Al Sewice Tourses	2	54 Carrol	1 St., N	W, Washing		neral Home 20012
	Physician /Medical		resulting in death)	Myocardi	er the mode of dying		or respiratory arrest,		Approximate Intervat Between Onset and Death 6 days
	Examiner	<u>.</u> .	Due to (or as a con	ry Arter	y Disease	шч			10 years
Ď,	cate be executed physiclen and s the burial-transit	Examiner	nf any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conductor)						
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O. Box	ires that the death certifi signed by the attending d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 [	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
rds, r	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc		to the cause of death?
Vital Record	The law ate has b page 2 si	Completed					24a. Was an autopsy performed 1 Yes 25	prior to death?	utopsy findings avaitable completion of cause of s
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 **Impatient*	2 ER/Outpatien	Dthe	-	n <i>(Check only one)</i> me 5 ☐ Residence	€ □Other (€s	north I
lon of	ling After fune	<b> -</b>	27. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation 2 28a. Date of Injury (Month, Day Yea		f 28c. Injury Work		28d. Describe how in		G.J.Y)
DIVISION	2 2 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, str oecify)	reet, factory, office		28f. Location (Street City or Town, St		Rural Route Number,
	6 수 일 등	Medical	29a. Certifier (Check only one)  1X**Certifying Physicien: To the best of my 2 Medical Exeminer: On the basis of exa and manner stated.	knowledge, death mination and/or in	vestigation, in my op	inion, death occur	red at the time, date	and place, and du	e to the cause(s)
)	within 2	×	29b. Signature and title of certifier		29c. License	number 29.293		Date signed (Monarch 13,	
	\ •		30. Name and address of person who completed cause of death Michael Lincoln, MD 1400 For		,	ver Spri	ng, MD 209	910	
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 4 2006  32. Degistrar's 8	Signature	parte				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) March 7, Day006 Year **Physician** CARMEN de LOURDES SANTIAGO 11:38А м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 5. Social Security Number 584-38-3859 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or F. Country) Nov. 23, 1951 Puerto Rico 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 🕅 F Months Days Hours 54 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in then "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Md. Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 United States 9559 Fern Hollow Way by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. and Health and Mental Hygiene. It is the T I e marked other then "natural, or itel and yor other treumatic event, the Modical Exeminatury, or other treumatic event, the Modical Exeminatury. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carmen Otero Miguel Maldonado ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 le eny Injury or other tresonce. 9559 Fern Hollow Way Montgomery Village, Md. 20886 Vincent J. Santiago (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. Alexandria, Va. 4 Donation 5 Other (Specify) 2006 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenurtis 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEFT URETERAL 50HRS Physician Obstruction from Mid URETERIA STONE /Medical Due to (or as a consequence of): Examiner 50 MRS INFEGRON LEFT KICHEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine 18 mrs attending physician and for use as the burial-transit POSEPSIS that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 15 MRS Physician/Medicai Branovic SHOCK NECHTLE IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Cther (specify) signed by the at d be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient မှ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Surhago Carr Released by 28d. Describe how injury occurred Medicai Certification 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO- DU08738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 ROCKVILLE Pike #208 Rochville, My 2095 31. Date filed (Month, Day, Year) MAR 1 4 32 Registrar's Signature State 14 Registrar

Examiner

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Mar. 10, 2006 10:58AM **Physician** Phyllis Marie Savov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Aquasco 23110 Neck Rd. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 48 Oct.11,1957 Maryland 217-74-5897 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State rai', or items 23s or 28s-f show Examinational be notified at 1 Yes 2 □ No Prince Georges Aquasco MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20608 USA 23110 Neck Rd. death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married Black 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "netural" the Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than any injury or other treumstic event. Item Lefty's Resturant Cook 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary A. Chapman William L. Savoy, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23110 Neck Rd, Aquasco, Md 20608 Mary Savoy/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mary's CHurch 3/16/06 Bryantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Puneral Service Licenses Adams Funeral Home, PA 20605 Aquasco Aquasco, Md 20608 Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a conseque ce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Year in the past 12 months? 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No 26. Place of Death Check on o e Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 residence 6 Other (Specify) Hospital: 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred in by the funeral 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide filled within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1400 Forest Glenn Dr. Ste. 435 Silver Springs, MD Harminder Sethi, MD 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 5 2006 Registrar

			1 - For State Registrar	State of Ma	arylar		artmen tificate			Mental	Hygie Reg.		6 (	971	P. Grade
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	<ul><li>Funeral Director</li></ul>		5. Social Security Number 6. Se		(In yrs.	last birthday) 89 Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Mir	. (Mon	th, Day, Ye		9. Birthpl Count	ace (State of	r Foreign
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Baltimore, Maryland 21215-0036	d within 72 h jiene. ir then "natu ir the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done du	on ring most of wo	orking		Kind of Bus		,	
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or compositions, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Acute Ca	e. rdiac rconseq	Arrest				c or respira	tory arrest,			Approximate Interval Betw Onset and D	veen
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O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Feta	Ideath 3□	Ectopic pre		4			23d. Date Mont		•	'ear
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0	ding Phys .r After this funeral di	ıtlon: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No  27. Manner of Death  1 X Natural 5 ☐ Pending  2 ☐ Accident investigation	Hospital: 1 Anpatier 28a. Date of Injury (Month, Day)	/	ER/Outpatien 28b. Time of Injury		A Other: Bc. Injury a Work?	4   Nursing	Home 5	Residence	6 Other		)	
DIVISION	5 H 2 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At ho . (Specif	ome, farm, stre	eet, factory,	, office		28f. Loca City	tion (Street or Town, St	and Number ate)	r or Rural	Route Numb	⊅e <i>r</i> ,
	To the Hospital within 24 hours e To the Funeral Completely filled	edical	29a. Certifier 1X Certifying Phy (Check only one) 2 ■ Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examina	wledge, death tion and/or inv	occurred a estigation,	at the time, in my opin	date and plac ion, death occ	e, and due t urred at the	o the cause time, date a	(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)	
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を	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 4 200	32/Registra		ture	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 24, 2006 **Physician** 0425 A M Charles  $\mathbf{E}_{ullet}$ Trott, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or roreign Country)
Aug. 30, 1924 Washington D.C. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 🛣 M 2 🗆 F 81 Director 577-38-5184 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State rat', or Items 23a or 28a-f show Examiner must be nutilied at 1X Yes 2 □ No Aberdeen Harford Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 540 Bonnie Dr. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. illed within 72 hours after Affred Forces?

1 Na Yes 2 No WWII

If Yes, Give Korea

Year or Dates: Korea

Vietnam 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Engineering 12 2 should be filed v and Mental Hygie is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna R. Hunsaker Charles E. Trott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) E. Mae Trott (Spouse) Aberdeen, Maryland 21001 Health tem 27 540 Bonnie Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State R. A. Ferris & Co. 3/27/06 West Chester, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Fnysician /Medical **Examiner** Wholen sis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner Vernont & Due to (or as a consequence of): burial-DENTERSION Physician/Medical Box IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 Yes 2 700 Be 25. Was case referred examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manny of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) del mined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

Registrar

State

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erson who completed cause of death (Item 23a) (Type, Print)

			For State Registrer	State of Marylan	d / Depa		Health and	Mental Hy		106	09743
	4 T SE		Decedent's Name (First, Middle, Last)	)				2. Date of Dea		.,	3. Time of Death
	Physicia		James Larry Th	omas				March	Day 9	2006	1834 <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De	ath	4c. C	ounty of Dea	
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. PE	Director	Į	421-60-6683	XM 2□F 5	7 Yrs.	Months Bayo		Feb. 7,	194		labama
	pu ≱		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y. Town or Lo	ocation					10d. Inside City Limits
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	ter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ YNo		~~		(Specify Yes or No- erto Rican, etc.)		Black, Whit	te, etc.
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$\frac{1}{8}$	should be f and Mental h marked of umatic eva	7	Willie James							Tipto	
Nar	12 sh h and h sn r is n traum		19a. Informant's Name/Relationship (T)  James Hicks/Son		1			#2, Water			06705
Baltimore, Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or itams 23a or 28a-1 ahow or other traumatic event, the Modified Examinar main be notified at		20a. Method of Disposition			osition (Name of matory or other pla		Date		ation - City or	
יסר	nt of a		1 XBurial 2 ☐ Cremation 3 ☐ I	Hemovai from State				18/2006			
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Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		3	Town to III				d., N.E.			
	£		23a. Part1. Enter the disease, or comp	lications that caused the deat	h. Do not ent						Approximate
			shook, of heart failure. List only o	one cause on each line.							Interval Between Onset and Death
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x 68	ertific ling p e as	Physiclan/Med	IF FEMALE:	00- 16							
Вох	ath cuttend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[	Ectopic pregnan	су		23	ld. Date of de Month	elivery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Other (specify)					
P.O.	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	F.	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cause g	iven in Part I.	23e. Did t	obacco us	e contribute t	to the cause of death?
ds,	sign d be	d by	Diabetes	Mellitus				1 🗆 '	Yes 20X	[No 3□P	robably 4 Unknown
Ö	v requ	ete						24a. Was	an	24h Were a	utopsy findings available
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a	ician: The I certificate ha ector, page		OF Was seen referred to madient					1 ☐ Yes	2 <b>X</b> No	1 🗌 Ye:	s 2 No
₹	Physician: r this certific ral director,	) Be	25. Was case referred to medicat examiner?  1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpation	at 2004 0	thor	Death <i>(Check only o</i>		Other (Car	20.6.1
o	oding Physician: th. After this certifica	): To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Ini	urv at	28d. Describe			эспуу
On	Attending r death. ector: After by the fune	it it	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ⊒Yes 2∐No				
Division of Vital Records,	al or Attendii after death. I Director: Ai d in by the fu	fice	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injury - Activ	ome, farm, st	reet, factory, office	)	28f. Location (: City or Tox		Number or F	Rural Route Number,
á	s afte	Certification:	# [] Homicide	building, etc. (Specil	у)			City of 101	WII, State)		
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	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date	signed (Mon	nth, Day, Year)
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A	(2)		30. Name and address of person who d	completed cause of death (Iter	n 23a) Oype.	-	- 10				
1	-(2)		Victor E. Herr				., #240,	Clinton,	MD	20735	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature						
	Regist	rar	MAR 1 5 2006	Marie A	4						

			For 3-14-06 State Registrar Amend#'s 26.&	State of Mar 29d.PerPhys.	<b>yland</b> PGC a	/ Depa	artmen rtificate			and M		Reg. No.	006	09744
	Physici /Medic		Decedent's Name (First, Middle, Last)     YVONNE E. VAUGHN								2. Date of De Month MARCH	aath 11,	ž866	3. Time of Death 7:23A M
*	Examin	61.5	4a. Facility Name (If not institution, give s	7E				RT W	Location of ASHIN	IGTON		PF	County of Death	
Ľ	Funeral Director		373 32 4713	7. Age	(In yrs. Ia. 82	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 09/26/	ay, Year)	WASHI	lace (State or Foreigr try) NGTON, DC
	Aaryland f ahow	or	Usual Residence of Decedent  10a. State 10b. County  DC			Town or Lo							1	0d. Inside City Limits  1X Yes 2 □ No
	with the Marylar te or 28a-f ahow	Direct	10e. Street and Number 6710 PINEY BRANCH	RD. NW			10f. Zip	Code 0012				10g. Citiz	zen of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-f ahow important: if item 27 is marked other than "natural", or Items 23e or 28e-f ahow apprintly or other traumatic event. Ite Medical Exatranal must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:			Was Deced If Yes, spec	cify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White, BLA Specify:	etc.
21215-0036	d within 72 ho piene. r than "natur Ite Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4 <i>o</i> r 5+	)	16a. Dece (Give life. STATI	kind of wo DO NOT us	rk done d se retired	during mos )	t of worki	ng		nd of Business/Ind	_
	12 should be filed within " h and Mental Hygiene. r is marked other than " raumatic event, Ita Med	To Be C	17. Father's Name (First, Middle, Last) WILLIAM L. WASHING	TON							(First, Middle HNSON	e, Maiden	Surname)	
Baltimore, Maryland	is 1 and 2 shoily Health and Nitem 27 is ma		19a. Informant's Name/Relationship (Ty WALTER E. VAUGHN/S 20a. Wathood of Disposition	TEPSON	20b. Pla		ENYON	N ST	NW T	WASH:	INGTON,	DC 20c. Lo	cation - City or To	wn, State
Baltimo	permit. Pages Department of I Important: If ite any injury or or once.		XXBurial 2 Cremation 3 P 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens			COLN N	MEMORI 2. Name ar MARS	CAL DA Addres HALL		Jnera		OF N	TLAND, M MARYLAND ND, MD 20	,INC.
100	Priysician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused to be cause on each line.  ALZHEIME  Due to (or as a	R'S	DISEA	ter the mod							Approximate Interval Between Onset and Death 4YRS.
68760,	death certificate be executed e attending physician and od for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a  Due to (or as a										2200
.O. Box	the death certifica y the attending phace of the control of	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXVo 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3	⊒Ectopic pi ⊒ Other <i>(sp</i>					2	23d. Date of delive Month	ery Day Year
<u>α</u>	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con CHRONIC OSTEOMYE	-	t not resul	Iting in the u	underlying o	ause giv	en in Part!	l. 		tobacco u Yes 2		ne cause of death?
Records,	has has	Completed	HYPERTENSION								24a. Was auto perf 1 \( \text{Yes}		24b. Were auto prior to co- death? 1 \( \subseteq \text{Yes}	psy findings available mpletion of cause of 2 No
of Vital	ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  XYes 2 No  27. Manner of Death  XNatural 5 Pending investigation	Hospital: 1  Inpatien 28a. Date of Injury (Month, Day		ER/Outpatie 28b. Time o Injury		28c. Injur Wor	er: 4 🗆 N	ursing He	Check cnl XX 28d. Describe	}	Control (Specification)	ARETAKEK'S HOME
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hor (Specify)	me, farm, st )	reet, factor	y, office			28f. Location City or To	(Street an оwп, State	d Number or Rura )	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical		sician: To the best of ner: On the basis of and manner stat	examinad									
Λ	To the To the comple	Me	29b. Signature and title of certifier			712			e number OC 179	914		Mar	e signed (Month, Ch BRUAKY 1	
2	(12)		30. Name and address of person who could be seen and address of person addre	D 2	2021	K ST.		#300	) WAS	HING	TON, DC	2000	06	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 4 2006	82. Registra			Ke)							

	•	•	For State Registrar	State of Marylan	,	artment <i>tificate</i>			d Ment		iene	Section 2	09745
			Decedent's Name (First, Middle, Last)							ate of Deat	h	Vost	3. Time of Death
	Physicia /Medic		JOSEPHINE	ASKEW	WILL	AMS			MAĬ	RCH	07,	2006	4:00P M
Ē	Examin		4a. Facility Name (If not institution, give st.			4b. City, To		cation of De	eath			ounty of Death	
A.			PRINCE GEORGES H			If Under 1		VERLY	drs la n	ate of Birth	ŀ		GEORGES
	, Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs.	Yrs.				lin. (A	fonth, Day,	Year)	Co	place (State or Foreign untry) TH CAROLINA
No.			Usual Residence of Decedent									7 7.01	
	how	_	10a, State 10b. County		ty, Town or Lo	cation						,	10d. Inside City Limits  XX Yes 2 □ No
	8a-f e	cto	MD PRINCE GE	ORGES L	ARGO								
	with the	Funeral Director	10e. Street and Number			10f. Zip C		77/		,		n of What Co	
	eath	era	9705 SUMMIT CIRCL 11. Marital Status	2. Was Decedent Ever in U	.S. 13. \	Was Deceder		774 anic Origin?	(Specify )	res or No-		ED STA	ican Indian,
0	tiled within 72 hours after death with the Maryland Hygiene. other than "natural", or Iteme 23a or 28a-f ehow ent, the Medical Examiner must be notified at		1 Never Married 2 Married	Armed Forces?	ì	fYes, specifi 1 □ Yes 🔀			ierto Rican	, etc.)		Black, White	
2	ral', c	d by	<b>XX</b> Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Tes 424	<u>4</u> 3-NO .	Specify:			5,	pecify: BLA	ICK
ק	"natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual kind of work DO NOT use	done dur		working		16b. Kind	of Business/I	ndustry
V	within ene. than	шb	Elementary/Secondary (0-12)	College (1-4or 5+)		ANNIE	retirea)				DI	RIVATE	
ν 5	filed Hygid Sther ent,	ပိ	12TH 17. Father's Name (First, Middle, Last)		IN A	TIMINTE	18	B. Mother's N	Name (Firs	t, Middle, A			
O	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene for the flam 23a or 28a-f show then 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Mcdical Examiner must be notified at	To B	JAMES EDWARD WILL	IAMS				IDA	ASKEV	V			
ary	shou s ma		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (	Street and	d Number or	Rural Rou	te Number	City or T	own, State, Z	ip Code)
Ž.	and 2 salth n 27 i		IVESTIA WILLIAMS	/ DAUGHTER		SUMMI		RCLE		RGO, 1			
ore	ges 1 t of He if Iter or oth		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Re	moval from State	Place of Dispo cemetery, crem	natory or oth	er place)	į	Date		20c. Loca	ition - City or	Fown, State
palitimor	tment tant:		4 □Donation 5 □ Other (Specify)		SHINGTO							ITLAND	
Da	permit. Pages i Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licenses	ill		MARSHA 4308_s						RYLAND, MD 20	
1954 1954	* 1		23a. Part1. Inter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	th. Do not ent	er the mode	of dying,	such as card	diac or rest	oratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	HEMORRHAG	110	EREBA	CAL	VASC	WIER	A	CCID	ENT	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):								
		-	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consec	quence of):				-				
	uted Insit	Examine	cause. Enter Underlying Cause (Disease or injury		,								
<b>-</b>	executin and ial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):								
00/9	cate be executed physician and the burial-transit	dical	<b>€</b> d.										
Õ	ng ph		IF FEMALE:										
א מ	w requires that the death certific been signed by the attending p should be detached for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregn 1 Live birth 2 Feta	aldeath 3□	Ectopic pre					23	<li>d. Date of deli Month</li>	very Day Year
	the de	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of o	death 5	Other (spec	спу)						
7.	that the ed by detac	0	Part II. Other significant conditions cont	inbuting to death but not res	sulting in the u	nderlying cau	use given	in Part I.	:	23e. Did tol	acco use	contribute to	the cause of death?
coras,	uires Isign	d by							_	1 🗆 Y	s 2 🗆	No 3□Pr	obabiy 4 Unknown
Ö	~ D 70	iete							2	24a. Wasa		24b. Were au	topsy findings available
Ž	The law sate has b page 2 st	Completed							_	autops perform	y ned? 2∭X No	death?	completion of cause of 2 No
VITAI		BeC	25. Was case referred to medical examiner?				2	6. Place of I			•		
o   	Physician: this certific ral director,	70	1 ☐ Yes 2 No		ER/Outpatier		1		<del>- ,</del>			Other (Spec	city)
	ing P	i,	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		c. Injury a Work?		28d. I	Describe ho	ow injury (	occurred	
S	death death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm str	M factory		s 2 No	28f I	ocation (St	reet and	Number or Ri	ral Route Number,
DIVISION	after all in by	Certification;	4 ☐ Homicide determined	building, etc. (Speci	fy)	eet, factory,	OITICO		206	City or Town	. State)	740711507 07 712	var riodio riambor,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	(Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owledge, deat ation and/or in	h occurred at vestigation, i	t the time,	date and pl	lace, and d	lue to the c	ause(s) a ate and p	nd manner as	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner stated.			License r			- 2	9d. Date	signed (Mont	n, Dey, Year)
	F3F8	0	1 110		~	7	52	1865			3	-11-	06
1	5 (3)		30. Name and address of person who cor	mpleted cause of death (Ite	m 23a) (Type,	Print)							06
	DC.		DR K. MICHAEL	ELGARD	300	Print) 1 Hos	PITA	2 D	R	CI	<i>teve</i>	RLY, N	13 20785
8.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign								1	
	Regist	rar	MAR 1 4 2006	EN DE AN	-								

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Registrar

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	•	For State Registrar				rtificate				Re	g. No. U U	6	09/4/
Physician	n	Decedent's Name (First, Middle, I								Date of Death Month	Dav	Year	3. Time of Death
/Medica				William	IS	41. 67.		1 10		ARCH		006	6:30A. M
Examine	r	4a. Facility Name (If not institution, g 4406 68th PLACE		mber)				Location of D	eath		4c. County		n EORGES
Funeral			. Sex	7. Age (In yrs. la:		If Under	1 Year	If Under 24 I	Hrs. 8.	Date of Birth	1		hptace (State or Foreign
Director		578-98-7662	1 ☐ M 2 🖾 F	27	Yrs.	Months	Days	Hours A	Mai Mai	Date of Birth Month, Day, ch 5,	1979	Wasi	hington,DC.
and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
Maryl -f eho	ទ្ធ	Maryland Prince	George	Lan	dover	Hill	s						M∑Yes 2 No
n the	<u>e</u>	10e. Street and Number				10f. Zip	Code			10	Og. Citizen of \	What Co	ountry?
ath wit		4406 68th Plac						.0785			United		
er dez	nue	11. Marital Status	Armed Fo		. 13.	Was Deced If Yes, spec	ent of Hi	spanic Origin' n, Mexican, P	? (Specify uerto Rica	Yes or No- in, etc.)		e - Ame ck, White	rican Indian, e, etc.
J36	P P	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 □ Yes If Yes, Gi Year or D	ive		1 ☐ Yes	2 <b>X</b> No	Specify:			Specify	y: B1	.ack
21215-0036  Id within 72 hours after death with the Maryland glene.  In Medical Exprinter must be notified at the Medical Exprinter must be notified at the Medical Expresses.	Completed by Funeral Director	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua	at Occupa	ation	working		16b. Kind of B	usiness/	Industry
within within then the Man	dr.	Elementary/Secondary (0-12)		1-4or 5+)				furing most of )			0.1		
nd 2121 e filed within al Hygiene. I other then vent, tre My	S C C	12 17. Father's Name (First, Middle, La	st) 4		- CC	llege	Stu		Name (Fi	rst. Middle. N	School Maiden Suman		
ld be id be	To Be	Howard L. Wil					ĺ			arson		-,	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23e or 28e-1 show other traumatic event, the Medical Examples mailtied at	- !	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Number o	r Aural Ad	oute Number,	City or Town,	State, 2	Zip Code)
ore, M is 1 and 2 of Health, of Health; other tra		Howard L. Will	iams/Fat		A CONTRACTOR OF THE PARTY OF TH	The second second second					hts, MI		20743
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from			osition (Nan			Date		20c. Location	-	
Baltimo bermit. Page. Department o important: If any Injury or ance.	- 1	4 Donation 5 Other (Spe		Mt.		t Cem		y Mar		1,2006			ton, DC.
Depa Depa Impo		21. Signature of Funeral Service Lic	70/	helf	2	z. Name an	a Addres	S OF Facility	55. For	38 Mar restvi	eral Ho lboro I lle, MI	ike).	20747
760 te be ysicie	icai Examiner	disease or condition resulting in death)  Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	(or as a conseque	ence of):	10 N	o cu						
BOX 68 death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnan birth 2  Fetal ( nant at time of dea nown	death 3	□Ectopic pr □ Other (sp						ite of del onth	livery Day Year
	2	Part If. Other significant condition	s contributing to c	death but not resul	ting in the t	ınderlying c	ause giv	en in Part f.					o the cause of death? robably 4 Unknown
Vital Records, P.O slcien: The law requires that the certificate has been signed by th rector, page 2 should be detached.	Completed								-	24a. Was ar autops perform	y ned?	prior to death?	utopsy findings available completion of cause of
Vital Resident The La certificate ha irrector, page 2	Bec	25. Was case referred to medical examiner?							Death (C	heck only on			
A Signal	2	1) Yes 2 □ No				nt 3□ DC	-	4 LI NUISII	-				ocify)SCENE
• nding Peath. or: After he funering	ë	27. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investiga	In A Lond	nth, Day Year)	28b. Time of the control of the cont	AM 2	28c. Injun Wor	∕aτ k? Yes 2.⊠No		m.	cssew liter		
Division  or Attending after death. Director: After in by the fune	Certification;	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Pfac	e of fnjury - At hor ding, etc. (Specify)	6:38 ne, farm, s				28f.	Location (St.	reet and Numi	ber or Ru	ural Route Number,
Dital or urs after or all Dir illed in		.*.		ho	me				. 4	mal or		5,10	
DIVI To the Hospital or At within 24 hours after To the Funeral Direc completely filled in by	Medicai	29a. Certifier 1 Certifying (Check only one) Medical Ex	caminer: On the I	e best of my know basis of examination oner stated.	riedge, dea on and/or i	th occurred ivestigation	at the tin	ne, date and p pinion, death (	occurred a	due to the ca at the time, da	ause(s) and mate and place,	anner as and due	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	2.10 1.141			290	c. Licens	e number		2	9d. Date signe	d (Mont	th, Day, Year)
		Jasker	see	f ins			0.C.	M.E.		M	ARCH 6	, 20	06
R (6)		30. Name and address of person w	no completed cau	use of death (ftem	23a) (Type	, Print)			BAL		, MARYI		
State	e	31. Date filed (Month, Day, Year)		Registrar's Signati	ure								
Registra	ır	MAR 1 5 20	106	in &	400	List of							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 2006 WHITE 8:51 PM KATHERINE MAXINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F 67 Director 218-38-7945 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehov yry or other traumatic event, Ir a Micdical Examinar must be notified at Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20910 U.S.A. 2306 Kansas Ave, Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home-Maker Private llth Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Joppy 2 George Offutt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8319 Cypress Street, Laurel, Md #20707 Marsha Casey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Departion 5 Other (Specify) 3/16/06 Lincoln Park Rockville, MD 21 ignature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home à 246 N. Washington St Rockville, MD 20850 COCK 23a. Part1. Enter the dis see, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failing. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Admonar /Medical Due to (or as a densequence of) Examiner eroseler Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit hroniz Due to (or as a consequence of) Box 68760. Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fetonic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pg ad 4 🖫 Unknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Tes Medical Certification: To 2 No 1 Impatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. STEINBERG 106 Fruic 2400R No 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 14 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month Day Physician Robert Lee Winters, Sr March 17 2006 9:16 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Avalon Manor Health Care Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1**X**M 2□ F Months Yrs. 78 12 1928 Maryland Director 212-24-1163 Jan. Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If them 27 le marked other than "natural", or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Funeral Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e, Street end Number 10f. Zip Code 14211 Basore Dr U.S.A. Hagerstown 12. Wes Decedent Ever in U,S. Armed Forces? 1 D7 Yes 2 □ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Drill Operator Truck Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Albert Winters Myrtle Long Hite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Lee Winters, Jr 21600 Kelso Dr Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Injury or Burial 2 Cremation 3 Removal from State 4 □ Donetion 5 □ Other (Specify) 3/21/06 Hagerstown Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sig sture of Funeral Service License 1601 Fennsylvania Ave Hagerstown Maryland 21742 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) ( , ~ v be 5, 5 /Medical Examiner cancer Physician/Medicai Examiner rostat or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) urs efter death. eral Director: After this certificete hes been signed by the etter filled in by the funerel director, page 2 should be deteched for a 23b. Did tobacco use contribute to the cause of death? Part !!. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Medical Certification: To Be Completed by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 1010 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menper of Deeth 28a. Date of Injury (Month, Dey Year) 1 Natural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) within 2 To the ţ 29c. License number 29d. Date signed (Mogth, Dey, Year) 29b. Signature end title of certifier DUGU396 06 1126 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) ARID MUN HE 1 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

Part			for State Registrar	State of Maryla	-	artment of H			ene 2006	09751
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The State   150 Country   100 City; Town of Location   100 City; Town of L			186-42-3314			If Under 1 Year	II Under 24 Hrs	8. Date of Birth (Month, Day, ) July 19	9 F	Birthplace (State or Foreign Country) Maryland
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College (1-4or 5+)   Homemaker   Own Home	036 ours after deat al, or Itema 2	þ	1 Never Married 2 Marned	If Yes, Give	U.S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
20b. Place of Disposition Name at 20c. Function of 10 or 10 wm, St. 20c. F	21215-0 d within 72 ho giene. In then "netur the Medical	ompieted	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking 16		•
20b. Place of Disposition Name at 20c. Function of 10 or 10 wm, St. 20c. F	yland yould be file Mental Hygarked otheratic avent,	Be	Solomon	E. Rob	ison					ller
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25. Was case referred to medical example?  1	.O. Box 68 the death certific y the attending pl tched for use as t	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3					•
25. Was case referred to medical example?  1	rds, P quires that an signed b	Ď	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause give	en in Part I.			
26. Place of Death (Check only one)  27. Manne of Death  1 Natural  28. Date of Injury  29. Date of Injury		Complet						autopsy	prior	autopsy findings available to completion of cause of ? es 2 \( \sum \) No
Thomas J. Gilbert M.D. 251East Antietam St., Hagerstown, Md.	Vita ician: sertific ector,	Be	examiner?	Hoepital		Oth	or			
1   Matural   2   Accident   3   Suicide   4   Homicide   1   Continued   28e. Place of Injury - At home, farm, street, factory, office   28l. Location (Street and Number or Rural Route   City or Town, State)   29a. Certifier (Check only one)   29b. Signature and miles of certifier   29b. Signature and miles of certifier   29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   Thomas J. Gilbert M.D. 251East Antietam St., Hagerstown, Md.	Phy ald			1 ☐ Inpatient 2		III 3L DOA	4 🗆 Nursing			pecify)
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Thomas J. Gilbert M.D. 251East Antietam St., Hagerstown, Md.			30. Name and address of person who	completed cause of death (I	tem 23a) (Type		40004	19	Marcho	400,6
State 31. Date filed (Month, Pay, Year) 32. Hegistrar's Signature	TAXABLE DISTRICT	te	·	Gilbert M.[	252	•	ntietam	St.,Hag	erstown	, Md. 21740

			1 - For State Registrar		Mental Hygiene 06 09752								
	Physici	an	Decedent's Name (First, Middle, Last)  Decedent's Name (First, Middle, Last)  THE						2. Date of De Month	ath Day	Day Year		Death
	/Medic	al	Donald T.  4a. Facility Name (If not institution, give street and number)		e)	Watts		e Location of	March		8 2006 4c. County of Death		р^м
7	Examin	er	402 Dreams Landing Way		'/		4b. City, Town, or Location of Death Annapolis		Death		Anne Arundel		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs		ige (In yrs. la	st birthday)	If Under 1 Year   II Under 24 Hrs.		24 Hrs. 8. Date of Bir Min. (Month, Da	th	Q Birthologo (State		Foreign
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f ehow any Injury or other traumatic event, It is Mudical Examiner must be notified at once.		163-26-2617	XXM 2□F	73	Yrs.	Months Days	Hours	Min. (Month, Da Dec. 22	1932	Mar	yland	
			Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					10d. Inside Cit	v Limits
		ō	MD Anne A	runde1		Annapo						1 🗆 Yes	
		Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?	
		al D	402 Dreams Landing Way				21401				USA		
		Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in UArmed Forces?  1 XYes 2 No If Yes, Give Year or Dates: 1956			13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Rac	14. Race - American Indian, Black, White, etc.		
36		by F.				5-76 1□Yes XXNo Specify:			·		Specify: White		
8			15. Decedent's		: 1750		dent's Usual Occup	pation		16b. Kind of Br	usiness/lr	ndustry	
215		piet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired)			of working			,	
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		Be	17. Father's Name (First, Middle, La						's Name (First, Middle	, Maiden Suman	e)		
<u> </u>		ဥ	John Carroll Wa			4.0h . 14-18-			e McNulty	6h T-	0	- 0 - 1 1	
<u>a</u>		1	19a. Informant's Name/Relationship Nancy M. Watts						r or Rural Route Numb Way, Anna;				
<u>6</u>			20a. Method of Disposition	(WIIE)	20b. Pla	ce of Dispo	sition (Name of		Date	20c. Location -			
ē			1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		0		natory`or other pla n Nat. Ce	· 1	6-21-2006	Arlingt	on '	VΔ	
Baltimore,			21. Signature of Faneral Service Lig	4	711 1.		2. Name and Addre	ss of Facility	/		011,	V 21	
ñ			Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401										
	Coate be executed  Wedical  Ex  We burial-transit  I the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
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			resulting in death)	Due to (or a	s a conseque							7	
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			Sequentially list conditions, 1 any, leading to firm a late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Oue to (or as a consequence of the content of the conten			<u> </u>							
8760,		dicai		d									
9	ertifica ing ph e as t	Med	IF FEMALE:				-						
Box	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	e of pregnance 2  Fetal o	etal death 3 Ectopic pregnancy				23d. Date of delivery  Month Day Ye		ear		
o.		ysic	1			atn 5L	Other (specify) _						
<u> </u>		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to							obacco use contribute to the cause of death?			
rds		ed by	Biling Truct Cancer							I ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
000		piet	/						24a. Was	an 24b.	Nere auto	opsy lindings a	vailable
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Ita		Be C	25. Was case referred to medical examiner?				of Death Check only						
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5		ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year)				Wo		28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,				
Division of Vital Records,		Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)										
á		Serti	4 Homicide		City or Town				1, State)				
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			29b. Signature and title of certifier		29c. Licens	29d. Date signe	d. Date signed (Month, Day, Year)						
			> V X V L W				1000	Mard	March 8, 2008				
			30. Name and address of person wh	no completed cause of	death (Item 2	23a) (Type,	Print)	. ^	A i-	- 110	7	140,	
			Tenn ton	It MO	900 1	Ocsty	att #3	00	Anngo 1	3)100	41	40	/
da	Sta Registr		31. Date filed (Month, Day, Year)  WAR 14		trar's Signatu	re A	all		·				

filled in by within 24 hours after or To the Funeral Direct completely filled in by To the Hospital

> State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of

29a. Certifier

AMARA

Jamans WS erson who completed cause of death (Item 23a) (Type, Print) 116 Defense Hog

29c. License number

\*\*Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

09/2006

	550		For State Registrar		State of N	Maryland		artment <i>rtificate</i>			лептат ну	giene Reg No	006	09754
	Dhyoisi		Decedent's Name (	First, Middle, La	st)				- -		2. Date of De Month	ath Da	y Year	3. Time of Death
	Physici /Medi		Martha	W	ashington			Hartm	an		March	14	2006	11:10 PM
	Examir	ner	4a. Facility Name (If n	ot institution, giv	e street and number	r)				tion of Death		4c.	. County of Deatl	
				Nursing					lisbury	nder 24 Hrs.	1 a B (B)		Wicomi	
	Funeral Director		5. Social Security Num 220-48-08	78	Dex I□M 2XF	Age (In yrs. las.	Yrs.			urs Min.	8. Date of Bir (Month, Da 02/22/	iy, Year)		nplace (State or Foreig untry) sinia
	pue Ma		Usual Residence of D	0b. County		10c. City, 7	Town or L	.ocation						10d. Inside City Limits
	the Maryler 28a-f show	ō	MD	Somers	eet	Wee	tove	r						1⊠Yes 2□N
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	with well	Ō	7440 Menno		urch Road	i			21871					
	Jaseth Tis 23	era	11. Marital Status		12. Was Deceder	nt Ever in U.S.	13.			ic Origin? (Sp	pecify Yes or No Rican, etc.)		USA 14. Race - Ame	ncan Indian,
0	riter	Fun	1 Never Married	2 Married	Armed Forces						Rican, etc.)		Black, White	e, etc.
ž	urs a	by	3%Q Widowed 4	Divorced	If Yes, Give Year or Dates	S		1 ☐ Yes 2	No Spe	ecify:			Specify: Wh	iite
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a	2 sh and is m		19a. Informant's Nam			1						-	or Town, State, Z	
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P.O. Box 68/60,	- - - - - - - - - - - - - - - - - - -	by Physician/Medical Examin	21 Signature of Fune Shock, or heart if Immediate Cause (Fidisease or condition resulting in death)  Sequentially list cond if any, leading to immediate. Enter Underly Cause (Disease or injust in intiated events resulting in death) Last IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes	Other (Special rate of Special Service to compare of Special Service to compare of Special Service to compare of Special Speci	b. Due to (or a d. 23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown	Qui  100295  ed the death. line.  RATO as a consequer  As a consequer as a consequer  To pregnance 2 Fetal de at time of deat	netery, creating of the control of t	Cemetal Cemeta	ery Address of Funera Omerse of dying, suc	Facility  1 Home  t Aver  that as cardiac	3/2006 eue, Pri or respiratory a	nces	23d. Date of delimenth	MD 21853 Approximate Interval Between Onset and Death
Records, P.O. Dox 86/80,	aw requires thet the death certificate be executed  as been signed by the attending physician and  s should be detached for use as the burial-transit  all	by Physician/Medical Examin	21 Signature of Fune shock, or heart if shock, or heart if limediate Cause (Fidisease or condition resulting in death)  Sequentially list cond if any, leading to immicause. Enter Underty Cause (Disease or inj that initiated events resulting in death) Last IF FEMALE:  23b. Was decedent property in the past 12 mround in the past 1	Other (Special rate of Special Service to compare of Special Service to compare of Special Service to compare of Special Speci	b. Due to (or a d	Qui  100295  ed the death. line.  RATO as a consequer  As a consequer as a consequer  To pregnance 2 Fetal de at time of deat	netery, creating of the control of t	Cemetal Cemeta	ery Address of Funera Omerse of dying, suc	Facility  1 Home  t Aver  that as cardiac	23e. Did	Poco	23d. Date of deliment of the contribute to the contribute to the contribute to the contribute at the contribute to the c	MD 21853 Approximate Interval Between Onset and Death  very Day Year  the cause of death? cobably 4 Unknow topsy findings available
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VII al records, P.O. Box 00/00,	aw requires thet the death certificate be executed  as been signed by the attending physician and  s should be detached for use as the burial-transit  all	To Be Completed by Physician/Medical Examin	21 Signature of Fune Signature of Fune Shock or heart I Immediate Cause (Findisease or condition resulting in death)  Sequentially list condification in death)  Cause (Disease or injury cause (Disease or injury cause)  IF FEMALE:  23b. Was decedent properties of the past 12 mm. 1 yes 2 mm. 1 yes	Other (Special rate Service to compare Service to c	b. Due to (or a c. Due to (or a d. Due to (or	Qui  100295  ed the death. line.  RATOLIA as a consequer as a consequer 2   Fetal de at time of deat	netery, cree  nton  H.  Do not er  L.  nce of):  nce of):  ry  eath 3  th 5	Cemetory or other Cemetory or other contents of the contents o	ery Address of Funera Omerse of dying, suc gnancy cify)  26. Other:	Facility I Home T Aver Ch as cardiac	23e. Did 24a. Was auto perful 1 Yes  th (Check only one 5   Res	Poco	23d. Date of deliment of the contribute to the c	MD 21853 Approximate Interval Between Onset and Death  onset and Death  very Day Year  the cause of death? chably 4 Unknow topsy findings available completion of cause of
of Vital Records, P.O. Box 68/60,	ding Physician: The law requires that the death certificate be executed XI After this certificate has been signed by the attending physician and important director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	21 Signature of Fune Signature of Fune Shock, or heart if Immediate Cause (Fidisease or condition resulting in death)  Sequentially list cond if any, leading to immediate Cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent proving the past 12 mm. 1 Yes Immediate Corollary of Unknown  Part II. Other signification of the past 12 mm. 1 Yes Immediate Corollary of Corol	Other (Special ral Service tice)  disease, of comdisiure. List only nal  iitions. endiate radiate radi	pilications the cause one cause one cause on each one cause of	Qui  100295  ed the death. line.  RATOLIA as a consequer as a consequer 2   Fetal de at time of deat	netery, creating and the second secon	Cemetory or other Cemetory or other contents of the contents o	ery Address of Funera Omerse of dying, suc gnancy crity)  use given in t	Place of Dea	23e. Did 24a. Was auto perfi	Poco	23d. Date of deliment of the contribute to the c	MD 21853 Approximate Interval Between Onset and Death  onset and Death  very Day Year  the cause of death? chably 4 Unknow topsy findings available completion of cause of
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Registrar
DHMH 17 Rev 1/2001

State

Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yogesh Vohra M.D. 614 Easternshore Dr.

MAR 1 7 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State	State of Mai					(1) (1) (1)	00755
			Registrar		Ce	rtificate of	Death	2. Date of Dea	Reg. No. UU6	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Howard B. Will	iame				Mar. 4	Day Year	6:27PM
	/Medic	- 55	4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Death		4c. County of Dea	
	Examin	er	8504 Timothy R			Brandy			Prince	Georges
3 703 2	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birthday,		If Under 24 Hrs.	8. Date of Birt	h 9 Bir	thplace (State or Foreign
	Director		227-20-6054	M 2□F	80 Yrs.	Working Days		Apr. 2	,1925 Vir	ginia
1	w w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
1	f sho	ō	MD Prince G	eorges	Brandywi	ine				1 X Yes 2 □ No
4	17.58e	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
1	be filed within 72 hours after death with the Maryland tall Hygiene. Ital Hygiene. Id other than "naturel", or Items 23a or 28e-f show event, the Medical Examinating intelligent all event, the Medical Examinating intelligent all	Funeral Director	8504 Timothy Rd	•		2	20613		USA	
7	ems (	iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 14. Race - Ame Black, Whit	
9	nours after turel, or Ite	by Ft	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give	10/43	1 ☐ Yes 2 💢 No			Specify: Wil	nite
9500-61212	fure!		15. Decedent's Educ	Year or Dates:	12/45 16a. Dece	edent's Usual Occu	pation		16b. Kind of Business	/Industry
က် င	within 72 ene. than "na na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(Give	kind of work done DO NOT use retire	during most of worked)	king		
7	giene r tha	Completed	12	College (1940) 34		Horse Ti	cainer		Self Emp	loyed
2	tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u> </u>	snould to	ဥ	Jesse Frank					ohn Je		T 0 11
	A 10 = 0		19a. Informant's Name/Relationship (Ty) Cecile Williams			•			er, City or Town, State, ine, MD 2	
	n and Health em 27 ther to		20a. Method of Disposition	/ WILC	20b. Place of Disp	osition (Name of	234-7	Date	20c. Location - City or	
و	Pages nent of int: If it		1 🛱 Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Arling	matory or other place ton Nat	3/2	0/06	Arlington	, VA
			21. Signature of Juneral Service License	op	2	2. Name and Addr	ess of Facility	-	- 00605 3	D.1
n	permit. Departr Imports eny inj		> Lloyal		111			Δα	MD MD	quasco Rd
	W.		23a. Part1. Enter the disease, or complishock, or hear failure. List only or	ic tions that o used the cause on each line	he death. Do not er	nter the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	hysician	U,	Immediate Cause (Final disease or condition		Cond	ontie	Heart	Foilu	10	Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of)	01150				
*	Examiner	_	Sequentially list conditions,	Due to for on a	consequence of):					
	led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).					
	axecul and al-trai	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
09/	te be executed ysician and he burial-transit	cai		d						
89	leath certificate attending phys I for use as the									
ŏ	th cer lendir r use	an/N	23b. was decedent pregnant	3c. If yes, outcome o		□Ectopic pregnan	cy		23d. Date of de Month	livery Day Year
O. B	e dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death 5	Other (specify)				
<u>.</u>	The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the	Completed by Physiclan/Med	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause o	iven in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
ds,	signe d be d	d b	Adult - H	Enduce	1 1 .	MUE		1 🗆 '	Yes 2 □ No 3 □ P	robably 4 Dunknown
Records,	w requ been shoul	ete	Anemia	16.5	Heed			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Re	Physicien: The lav this certificate has al director, page 2	E D	- Manie		3 46 (				ormed? death?	
Vital	en: T tificati tor, pa	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only)		2010
	ysici is cer direct	08	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	t 2 ER/Outpatie	ent 3 DOA	ther: 4 Nursing H	lome 5 Resi	dence 6 Other (Sp	ecify)
0	rg fer ner	D: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	W	ork?	28d. Describe	how injury occurred	
Sio	ottendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2 ☐No	OOL Landing (	Carran and Mumber of C	2 ml Coute Mumber
Division of	or Att	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	ry · At home, farm, s . (Specify)	street, factory, office	9	City or To	Street and Number or F wn, State)	lurai Houle Number,
_	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 1 Certifying Pro	sician: To the best o	f my knowledge, dea	ath occurred at the	time, date and place	, and due to the	cause(s) and manner a	s stated.
	e Hos 24 h	Medical	(Check 201 2 Medical Exami	ner: On the basis of and manner stat	examination and/or	investigation, in my	opinion, death occu	irred at the time,	date and place, and du	e to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of centile	_		29c. Lice	nse number		29d. Date signed (Mor	th, Day, Year)
ł			- XMM	451	11)	Doo	55 724	/	3/10/0	06
1	2071		30. Name and starts of person who co	ompleted cause of de	eath (Item 23a) (Type	e, Print)	1 1 1	1 11 11 11	1 01 :=	Hall MD 20622
(	N) 121		31 Date filed (Month Day Your)	30 philippin	ME M	) 2745	Charlot	ie riali Ko	ac Charlette	HOLL OW NOH
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 5	2006	a de	parke				

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

ceath (Item 23a) (Type, Print)

egistrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dev. Year)

March 23, 2006

			1 = State Amend Item 2	State of Ma 23a per dr.	aryland / Der , <b>G8</b> 53,03/	partment of l 29/06dhb ertificate of	Health a Death	and Mer	ntal Hyg	jiene ag. Nö.	06	09757
	3	é	Decedent's Name (First, Middle, Landson L		·				Date of Dea	th		3. Time of Death
6	Physici		AMES	A. W	EALE				Month 3	Day	Year	0555 M
	/Medic Examin		4a. Facility Name (If not institution, gi		.,.	4b. City, Town, o	or Location o	of Death		4c. Cou	nty of Deatl	1
- E		Ť.	SHOCK TO	LAUMA C	ENTER	BAZ	Timo	RE C	ITY			_
美 美	Funeral	-			e (In yrs. last birthda)	/) If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth	Year)	9. Birth	nplace (State or Foreign untry)
	Director		126-20-3067	1 <b>☑</b> M 2□F	77 Yrs.	Mortus Days	110013	Do	(Month, Day	1928	New	Ýork
	D.	-	Usual Residence of Decedent		10c. City, Town or	anation		·····				10d. Inside City Limits
	aryla ehov	-	10a. State 10b. County									1 ☐ Yes 2 ☐ No
	88a-1	Scto		Anne's	Sudlers					0	- ( )	
	vith th	Director	10e. Street and Number 110 S. Churc	h C+		10f. Zip Code 2166	Ω		,	U.S.		untry?
	72 hours after deeth with the Maryland natural', or Iteme 23a or 28a-f ehow dical Examinat must be notified at	La l			- · · · · · · · · · · · · · · · · · · ·			-1-0 (01				ncan Indian,
	er de Item	by Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. Was Decedent of I If Yes, specify Cub	an, Mexican	gin? (Specifi i, Puerto Ric	an, etc.)		Black, White	
36	rs aft	ν.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑ Yes 2 □ I If Yes, Give Year or Dates:		1 ☐ Yes 2🔀 No	Specify:			Spe	cify:	White
21215-0036	hour	edit	15. Decedent's E		-1955	edent's Usual Occu	pation			16b. Kind o	f Business/	Industry
15	in 72 in ma	Completed	(Specify only highest g	rade completed)	(Giv	re kind of work done  DO NOT use retire	during most	t of working				,
12	within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5		ano Tune	er			Self	-emp	loyed
	Hygid other	BeC	17. Father's Name (First, Middle, Las	it)			1	er's Name (F	irst, Middle,			
lan	Mental Mental arked o	To B	Paul Weale				Dor	othy	Fe11	ows		
Maryland	2 shou and M Is mar aumat		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stree	t and Numbe	er or Rural R	oute Numbe	r, City or To	wn, State, Z	Tip Code)
	and 2 leelth a m 27 is		James Weale	(son	) P.O	• Box 59	9 Su	dlers	sville	e, MI	21	668
ē,	es 1 a of Hee of Item r othe		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	9	20c. Location	on - City or	Town, State
Ë	Pages nent of int; if it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			sville		3/16,	/06	Sud1	ersvi	11e, MD.
Baltimore,	그들은		21. Signature of Eureral Service Lice			22. Name and Addr	ess of Facilit	ty		G!	. 1	T C-b1
Ö	Depending Depending Popular In Processing Popular In Processing Popular In Processing Popular In Processing Pr		* ( )	ON.	M00510 ្បី	alena r 18 West	unera Cros	I HOI	me or	Ster ena.	MD.	L. Schaecl
3			23a. Part. Enter the disease, or con shock, or heart failure. List onl	mplications that caused	the death. Do not e	nter the mode of dy	ing, such as	cardiac or re			1.0	Approximate Interval Between
H	Physician		Immediate Cause (Final	9 0110 02230 011 02011	Ruptur	ed Aortic	Aneu	cysu,	2	4		Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):	UC & CC P	ع د	110	Korb	,000		- DO (+1C)
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	be executed sicien and burial-transit	Examiner	that initiated events	c								
o,	exe en ar rial-t	EX	resulting in death) Last	Due to (or as	a consequence of):							
1760,	2 2 9	icai		d								
68	w requires that the death certifica been signed by the attending ph should be detached for use as it	Ned	IF FEMALE:									
Вох	th ce tendi	by Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnanc	су			23d.	Date of del	ivery Day Year
	death he atten ed for u	sici	in the past 12 months?  1 □ Yes 2 □ No	4□Pregnant a 9□Unknown	t time of death	Other (specify)					MOTILI	Day 16a1
P.O	requires that the een signed by th hould be detache	Phy	9 Unknown						00 - 0:4.			Mar
	es th igned be d		Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause g	iven in Part I.					the cause of death?
ord	pino pino	ted							1 U Y	es 21/2/N	6 3   Pr	obably 4 Unknown
Records,	lawr as be	Completed							24a. Was a autop:	an 24	b. Were au	topsy findings available completion of cause of
ď	9 2 9	mo;							perfor	med? 2 <b>√</b> 2No	death? 1 ☐ Yes	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (C	Check only o	-		
<b>1</b>	Physician: this certific ral director,	To	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpat	ient 3 DOA	ther: 4 🗆 Nu	arsing Home	5 🗆 Resid	lence 6 🗆	Other (Spe	cify)
Division of	iding Phys th. After this funeral dir	ï.	27. Manner of Death  1 SNatural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time		ury at ork?	280	d. Describe h	low injury oc	curred	
Ö	Attending r death. ector: After oy the fune	Certification:	2 ☐ Accident investigate				∃Yes 2□	No				
Σį	r Att	‡ E	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office	9	28f	Location (S City or Tow	Street and Ni m, State)	umber or Ru	ıral Route Number,
	itel o rs aft rel Di											
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai		Physician: To the best aminer: On the basis of								
	the h the f	led	one)	and manner st								
	5 th 00	Σ	29b. Signature and title of certifier	200	140 1	29c. Licer	nse number	1	1 '	29d. Date Si	gnea (Mont	h, Day, Year)
7			Maund	WYY	KIDMAS	PI	984	1		3/	12/0	06
	1all		30. Name and address of person wh	o completed cause of	death (Item 23a) (Typ	e, Print)		1.1	7	8,1.		2 1
	411		YAIRU	NON	1. 7/	10175	- ),	JUCK	11	· reren	(6	NH2.
100	Sta Regist		31. Date filed (Mohth, Day, Year)	32. Regist	rar's Signature	PI (om 95						
*		40	MAR 2 0 2	006	JA A	SHE)						
DH	HMH 17 Rev 1/2	001		The same of the same of	-							

ORIGINAL

			For State Registrar	State of Marylar		partment of He e <i>rtificate of D</i>		ental Hygie Rag.	4000	09758
	Dhuaiai		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Edward Joseph	Zisk				3 /	4 2004	
	Examir		4a. Facility Name (If not institution, give	e street and number)	Contr	4b. City, Town, or I	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S 166-38-8582	7. Age (In yrs.	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 4/2/1945	9. Bi	rthplace (State or Foreign ountry)
	pu ,		Usual Residence of Decedent	10.0						
	anyla	5	10a. State 10b. County		ity, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
	Ne M	ecto	MD Wicom	ico l	ittsv			T		
	with	늅	10e. Street and Number	n 1		10f. Zip Code 21850		10g.	Citizen of What C	Country?
	na 23	era	4920 Powellville	12. Was Decedent Ever in U	IS 13	3. Was Decedent of His	panic Origin? /Sne	ofy Ves or No-	14. Race - Am	erican Indian
21215-0036	should be filed within 72 hours after death with the Maryland nd Maniel Hygiane. marked other than "natural", or itama 23a or 28a-f ahow martic avant, ita Madical Exaridi ar musi La notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  122 Yes 2 No If Yes, Give Year or Dates: 1966		If Yes, specify Cuban  1 ☐ Yes 2€□XNo	Mexican, Puerto I	Rican, etc.)	Black, Wh	ite, etc.
Ō	2 ho	Completed	15. Decedent's Ed	ducation		edent's Usual Occupat		166	. Kind of Business	s/Industry
215	thin 7	ple	(Specify only highest gra	College (1-4or 5+)	life	ve kind of work done du . DO NOT use retired)	iring most of workii	ng		
7	erth	Son	12		Con	struction			Marine (	Construction
Maryland	- 0 =	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Mail	,	
<u> </u>	ould be Mentel arked o	ဥ	Stanley Zisk				Cather	ine Mazu	<u> </u>	
<u>a</u>	2 sh and is m	l y	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Street ar	nd Number or Rura	i Route Number, Ci	ty or Town, State,	Zip Code)
e o	and Health Im 27		Kathleen Zisk	206		20 Powellv				
altimore,	if its		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery, c	position (Name of rematory or other place,	)		. Location - City o	
	it. Pa rtmer rtent njury		4 □ Donation 5 □ Other (Specify 21. Signs of un Service Licen	•		lopen Crem	1 2/ 13/		rankford	
Ba	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		21. Signature of un Service Licen	Bushow		22. Name and Address 108 Willia		ne Burbag erlin. MD		1 Home
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not e					Approximate
В	Physician		Immediate Cause (Final disease or condition	metes fo						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		hay Con-	ree.			6 months
	Examiner		Sequentially list conditions,	b						
	D #	iner	cause. Enter Underlying	Due to (or as a consec	quanta of):					
	and and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	vuonna afti:		_			
58760,	icate be executed physicien and s the burial-transit			200 to (or as a consec	querice or).					
		edicai		_ d.						
×	leath certifi attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy				23d. Date of de	livon
X Q	death certif e attending d for use a	clar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnancy			Month Month	Day Year
		Physician/M	9 Unknown	9□ Unknown						
	res that igned to be det	by P	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying cause giver	in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
ğ	- w -							1 🗆 Yes	2 No 3□P	robably 4 Unknown
ပ္သ	law requ ss been 2 should	Completed						24a. Was an	24b. Were a	utopsy findings available
ř	The ete h page	E						autopsy performed	death?	completion of cause of s
Division of Vital Records,	ician: T certificet ector, pr	Be	25. Was case referred to medical examiner?				26. Place of Death			
<u>-</u>	Physic this ce al dire	2	1 ☐ Yes 2 € No	Hospital: 1 Inpatient 2	ER/Outpate	ent 3 DOA Other	4 🗆 Nursing Hon	ne 5 🗌 Residence	6 Other (Spe	ecify)
0 C	ite ng		27. Manner of Death  1. ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		at 2	8d. Describe how i	njury occurred	
<u> </u>	ttandi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	ו		M 1 1 Ye	es 2□No			
$\leq$	or At after of Diraci in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, : fy)	street, factory, office	2	8f. Location (Street City or Town, S.		lural Route Number,
_	Hospitel 24 hours a Funeral tely filled		29a. Certifier 12 Certifying Ph	veicing. To the heat of multiple						
	To the Hospitel or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	dical	(Check only one)	ysician: To the best of my knoniner: On the basis of examination and manner stated.	ation and/or	investigation, in my opin	nion, death occurre	nd at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Medi	29b. Signature and title of certifier	1		29c. License	number	29d.	Date signed (Mon	th, Day, Year)
			1 h	I n.o		23	0690	M	ic-Ch 1.	9 2001
				completed cause of death (Itel		e, Print)				
7	13+1			32. Registrar's Sign			1 5t. 3	5-1:560	, mi	<i>D</i> .
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
	Registr	- 3	MAR 15 2	2006 Seen	K 1	porte				
DHN	AH 17 Rev 1/20	001		/	ance 140	C. T. S. C. C. C.				

ORIGINAL

			1 - For State of Registrar	of Maryland /	Departmer		nd Mental Hyg	iene	09759
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Anderzo  4a. Facility Name (If not institution, give street and nu	(O)	4b. City,	Town, or Location of	2. Date of Deat Month McMcLy	Day Year	3. Time of Death
	Funeral Director		5. Social Security Number  6. Sex  180 M 2 F  Usual Residence of Decedent	7. Ago (In yrs. last t	birthday) /if Under Months	Wear If Under 2 Days Hours	4 Hrs. 8. Date of Birth (Month, Day)	Year) 9. Bin Co	hplace (State or Foreign unitry)
	the Maryland 28a-f show	Director	10a. State 10b. County  MD BAKIMORS  10e. Street and Number		Own or Location  AUSTOWIU  10f. Zig			0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
99	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23s or 28s-f show The Medical Examinational be notified at	Funeral	8440 ALLENSWOOD ROAD  11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Neve	edent Ever in U.S. prces?		21133 dent of Hispanic Orig city Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	ncan Indian, e, etc.
21215-0036	within Bne.	Completed by	15. Decedent's Education (Specify only highest grade completed)	1-4or 5+)	Sa. Decedent's Usu	al Occupation ink done during most se retired)	of working	16b. Kind of Business/	ACK Industry
Maryland 2	be filed Ital Hyg ed othe svant,	To Be C	17. Father's Name (First, Middle, Last) BERNARD ANDERSON	<u>K</u>	50.1 DRV100	18. Mother	's Name (First, Middle, M		
	1 end 2 Heelth e sm 27 ls ther trai		19a. Informant's Name/Relationship (Type, Print)  BESSIE ANDERSON (W  20a. Method of Disposition	IFE) 8	3440 ALLE	NSWOOD F	ROLL ROUTE NUMBER ROLL RANDAL	and the state of t	ND 21133
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	State	180N FORE 22. Name an	287 0	4.03.06 C		IILLS, MD
	Physician		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on timmediate Cause (Final	each line.	o not enter the mod	de of dying, such as d	RE, BAUTO M ardiac or respiratory arm	0 21229	Approximate Interval Between Onset and Death
3760, <	/Medical Examiner	Ical Examiner	S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence	AUVIS de ot):	1 ps th			
P.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	in the past 12 months?	tcome of pregnancy pirth 2 Fetal deal nant at time of death own				23d. Date of del Month	ivery Day Year
Records, P	w requires thet the been signed by should be detact	þ	Part II. Other significant conditions contributing to d	eath but not resulting	g in the underlying o	ause given in Part I.		pacco use contribute to	o the cause of death?
al Rec		Completed	25. Was case referred to medical				24a. Was a autops perform 1 Yes 2	ry prior to death? 2 2000 1 ☐ Yes	stopsy findings available completion of cause of
Ξ	Physician: This certifical ral director, p	To Be	examiner?	Inpatient 2 ER/C	Outpatient 3 DC		of Death <i>Check only on</i> sing Home 5 Reside		cifu)
Division of Vital	ling After fune	Certification; 7	27. Manner of Death  1  Ablatural	of Injury 28b	D. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe ho	ow injury occurred	
DÌVİ	To the Hospitel or Attend within 24 hours effer death To the Funeral Director: completely filled in by the i		determined 200. Flace	of Injury - At home, ing, etc. (Specify)			City or Town		
	ha Hos in 24 h he Fur pletely	edical	(Check only 2 Medical Examiner: On the b	asis of examination a ner stated.	and/or investigation	, in my opinion, death	n occurred at the time, da	ate and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		290	. License number		9d. Date signed (Monti	
,	6		30. Name and address of person who completed caus	se of death (Item 23a	a) (Type, Print)	7437	14 h	earty?	7, 2006
	Sta Registr			egistrar's Signature	Tours	spital	Randolle	Noun!	haigle, and
	negisti	ai .	MAR 3 0 2006 A	CHECKED SU.	Parantal				

		1	For State Registrar	State of M	aryland		urtment of I				iene	06	09760
	Physicia		1. Decedent's Name (First, Middle, Las Cella M. Askev							2. Date of Death Month	Day	3 2000	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		)		4b. City, Town, o	or Location	of Death	0101	4c. C	County of Deal	
1			Genesis Healtho				Parkvi		24 Hrs	Data of Birth		Balti	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9X □M 2\1 F 7. A(	ge (In yrs. Ia 7 (	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birth (Month, Day, 10-17-	Year)	N.	hplace (State or Foreign buntry) Carolina
	D		Usual Residence of Decedent  10a. State 10b. County		10c City	. Town or Lo	cation						10d. Inside City Limits
	death with the Maryland ms 23a or 28e-1 show	ī	MD n/a		1	altim							1 Yes 2 □ No
	th the	irec	10e. Street and Number		1	4 <b>L</b> C <b>L</b> III	10f. Zip Code			10	0g. Citiz	en of What Co	puntry?
	ath wi	rai	1305 Meridene I	rive	Cups in 11.6	12.1	212		ioin? (Spec	ify Voc or No.	1	USA 4. Race - Ame	erican Indian
920	172 hours after death with the Marylar "neturel", or items 23a or 28e-1 show clical Exercit er mast be notified at	by Fur	11. Marital Status  1 (XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Tyes 2 X  If Yes, Give  Year or Dates:	No		Was Decedent of I fYes, specify Cub 1 ☐ Yes 2ሺ No			ican, etc.)		Black, Whit	
215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give life. I	tent's Usual Occu kind of work done DO NOT use retire	pation during mos d)	st of workin	g		d of Business	<sub>Andustry</sub> kins Hosp.
12121	e filed within al Hygiene. I other than vent, the Ma	Con	17. Father's Name (First, Middle, Last)	2		Nu	rse	18. Moth	er's Name	(First, Middle, M			1
and	ild be f lental F ked of	To Be	William Askew					Lov	ethe	1 Bunc	h		
Maryland	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 is marked other than other treumatic event, the M		19a. Informant's Name/Relationship ( Cynthia Yvonne	Tonos Dau	ghte	19b. Mailir	ng Address (Stree	and Numb	er or Rural	Route Number	, City or	Town, State,	Zip Code)
e, P	1 and Health Iem 27 Sther tr	1	20a. Method of Disposition	Jones			05 Mer i		Dri Da	ve, <u>Ba</u>	1 <b>L t</b> 0 20c. Loc	Md 2 ation City or	1239 Town, State
E O	Pages nent of nt: If it ry or o		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific			tro C	remator	·v 3	-29-	06		to. M	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item eny injury or othe		21. Signatur of Funeral S. Mce Licer	MAL	_	9	200 Lil	perty	Rd.	, Rand	la11	A.of stown	Ralto Co. , MD 21133
	.8.		3a Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death line.	. Do not ent	er the mode of dy	ng, such as	cardiac or	respiratory arro	est,		Approximate Interval Between Onset and Death
	Physician /Medical	ij	Immediate Cause (Final disease or condition resulting in death)	a Due to for N	y OC	a / O	121 1	nja	reli	070			
	Examiner		Sequentially list conditions	e (e)	epn	el l	lascul	or 1	+cc	dont			
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ience of):							
), V	be executed ician and burial-transit	i Examine	that initiated events resulting in death) Last	C Due to (or a	s a consequ	uence of):							
68760,	icate b physic s the bi	dicai	•	d									
Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[	Ectopic pregnand Other (specify)	;y			2	3d. Date of de Month	livery Day Year
ds, P.O.	uires fhat fhe d signed by the lid be detached	by	Part II. Other significant conditions of	contributing to death	but not resu	ulting in the u	nderlying cause g	ven in Part	ł.	Ц	bacco us		o the cause of death? robably 4 Dunknown
Division of Vital Records,	The law requir ate has been si page 2 should	Completed								24a. Was a autops perform	SV	24b. Were a prior to death?	utopsy findings available completion of cause of s 20 No
Vita	nysicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0	han and		(Check only on			
of	ding Phys n. After this of funeral dir	n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of In (Month, D		28b. Time o	N 3 DOA	4/1		ne 5 ☐ Reside 8d. Describe he			ecity)
sion	utending (death.ctor: After	catio	1 Natural 5 Pending 2 Accident investigatio	n		Injury	M 1[	Yes 2					
Divis	ital or Att rs affer de el Directo led in by t	Certification;	3 Suicide 6 Could not be determined	200. Flace of I	njury - At ho etc. <i>(Specif</i> )	ome, farm, st	reet, factory, office		2	28f. Location (Si City or Town	treet and n, State)	d Number or Fi	lural Route Number,
	To the Hospital or Attanding Physicien: within 24 hours after death.  To the Funerel Director: After this certifics completely filled in by the funeral director.	ledicai	(Check only 2 Medical Examone)	nysician: To the bes miner: On the basis and manners	of examinal	wledge, deat tion and/or in	vestigation, in my	opinion, de	nd place, a ath occurre	d at the time, d	late and	place, and du	e to the cause(s)
	To To con	W	29b. Signature and title of certifier	ttondir	y PI	ysica	on L	se number	64	2 /	lar	ch 2	th, Day, Year) 8 2006
	3		30. Name and address of person who	5601	Loc	hK	Print) -aven	Blus	7 30	3 Bal	(+in	nose 2	1239
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 3 0 2		trar's Signa	k A	nack)						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John William Bailey Jr. 29, March 2006 12:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 103 Shady Nook Court Baltimore Catonsville 8. Date of Birth (Month, Pay, Year)
May 13, 1920 of Columbia If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) D1ST11CT 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 85 215-14-5434 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Catonsville Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 103 Shady Nook Court 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1941 If Yês, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examination. 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Illustrator Westinghouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John William Bailey Sr. Ruth Halterman 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Louise Bailey, Wife 103 Shady Nook Court Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/01/06 Zion Cemetery Highland Maryland 21. Signature of Funeral Service Ligensee
Thomas Gregor <sup>22</sup> Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Physician YEARS /Medical Due to (or as a consequence of): Examiner Sequentiatly list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner cate has been signed by the attending physiclen and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 B No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pendina М 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature aportitle of certified D1858 Name and address of person who completed ause of death (Item 23a) (Type, Print) BALTIMURE GORMUE ATON legistrar's Signature 31. Date filed (Month State 2006 Registrar

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Trede

32. Registrar's Signature

2006 0

Rd. Gforgville,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per ME C853,03/20/06dhb
State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per entiricate of Death
Reg. No. 1 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 Ruth Virginia Baumgartner /Medical 4b. City, Town or Location of Death 4c4County of Death Facility Name (If not institution, give street and number) Examiner Air Health and Rehab, lation If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 5. Social Security Number Age (In yrs. last birthday) Year Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🂢 F 91 Yrs Oct 9, Director 214-05-9023 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. Ite Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 410 E. MacPhail Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 12 hairdresser cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arthur Whisner Daisy Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melita Maxwell/daughter 501 Woodbury Way Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition õ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or gree. 4 ☑ Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature Funeral Servi Ronal S. Wade won Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) osteome 1145 **Physician** weeks /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit 2 titrom Exam that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER and Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of h Check only one examiner? Hospital: Other: 1 ▼ Yes 🛥 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 27. Manner Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 🛣 ☐ No 24 hours after death.

Funeral Director: A 2. Accident 3:15 p<sup>M</sup> investigation subject fell 10/31/2005 28f. Location (Street and Number or Rural Route Number, City or Town, State) 410 E. MacPhail Rd. BelAir Health & Rehab. Relair, Mr. 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Nursing home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (CHECK ONLY 29b. Signature and title of certifier bertA 29d. Date signed (Month, Day, Year) March 29, 2006 DUNCAU 30 Name and address of a son who completed cause of death (Item 23a) (Type, Print) Rd

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records,

Saumgartner

32. Registrar's Signature

W. MACPINE

31. Date filed (Month, Day, Year)

MAR 2 9 2006

				Please Type or Print						
			4	For State of Mary  1 - State Registrar	•	irtment of <i>tificate of</i>	Health and Me f <i>Death</i>		2.006	09764
		Physicia	_	1. Decedent's Name (First, Middle, Last)  Janet T. Brulinski			1	Month 27,	Day Year 2006	3. Time of Death 9:23 a M
		_/Medic	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town,	, or Location of Death		4c. County of Death	
		Examin	er	Upper Chesapeake Medical Cer	nter		Bel Air		Harford	l
	local control	Funeral Director			yrs. last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs. 8 s Hours Min.	Date of Birth (Month, Day, Ye	9. Birth Cou 1943 Mary	place (State or Foreign ntry) Tand
	9/	D		Usual Residence of Decedent	lc. City, Town or Lo	cation				10d. Inside City Limits
		Maryla	ctor	Md. Harford		F	orest Hill			1 ☐ Yes 2 💆 No
B		with the a or 28 Le no	Dire	10e. Street and Number		10f. Zip Code	050	10g.	U.S.A.	ntry?
~		eath	era	1718 Ingleside Road  11. Marital Status 12. Was Decedent Eve	r in U.S. 13. V		f Hispanic Origin? (Speci uban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Amer	
9.23 an	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show vary fujury or other traumatic event, it a Madical Examinar maint be notified at ODGs.	by Funeral Director	Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1 Yes, Give   1		fYes, specifyCu 1□Yes 22K□N		can, etc.)	Black, White Specify: W	nite
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Q	aryland 2121	d be filed antal Hyg ted other c event,	Be	17. Father's Name (First, Middle, Last)  James A. Mulcare			18. Mother's Name (		iden Sumame)	
00	Mary	12 should he and Me 7 is mark	ို	19a. Informant's Name/Relationship (Type, Print) Daniel T. Brulinski/husband	19b. Mailir	ng Address <i>(Stre</i>	et and Number or Rural	Route Number, C Forest H	ity or Town, State, Z	ip Code) 21050
27	re, l	s 1 and if Healt itam 2 other	d.	20a. Method of Disposition	20b. Place of Dispo		Da	Later and the second	c. Location - City or 1	
3	Baltimor	Page Iment c tant: If					Cem. 3/31/	2006 B	altimore,	Md.
	Ball	Departition Depart		21. Signature of Funeral Service Licensee	S	Name and Add	k Funeral H	ome of B	el Air, I	nc.
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		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a c	S ( S					
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53			dicai	d						
7	Box 6	leath certificate attending physic for use as the	n/Me	IF FEMALE: 23c. If yes, outcome of 23b. Was decedent pregnant		∃Ectopic pregna	nov		23d. Date of del	,
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R	= R	ysician: The is certificate hi director, page	Com					performe 1 ☐ Yes 2	od? death? ⊉No 1 ☐ Yes	2□ No
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Brulinski	n of	ng Phys fter this c	on; To	1 Yes 2 Xoo 10 Popular 1 Appatient  27. Manner of Death 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	of 28c. I	njury at 2	8d. Describe how	ce 6 □Other (Sperinjury occurred	ory)
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J.	ā	pital or ours aft aral Di		29a. Certifier 12 Certifying Physician: To the best of		th occurred at th	e time, date and place, a	nd due to the cau	ise(s) and manner as	stated.
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				lay /ll	th (Itaar 20a) CT	Daint)	022843	V	nurrey 48,	2006
		3		30. Name and address of Person who completed cause of dea	MOUNTY	Mihlb d	s Foren	HICK	M) 2	10170
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	/Medic		NAOMI A. BLIML				45 035	T	1	10	MAR		27, 20		S E.W
-	Examin	er	4a. Facility Name (If not institution, a Saint Joseph			ter	4b. City,	rown, or	Location of	OWS C	n	40.	County of De Ba	ltimore	<u> </u>
	Funeral Director		5. Social Security Number 6 219-16-9250	Sex 7. Ag	ge (In yrs. 82	last birthday) Yrs.	If Under Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Bird (Month, Da 5/29/1	th y, Year) 923		inthplace (State (Country)	or Foreign
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation			-				10d. fnside C	ity Limits
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	dear dear	ner	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Dece	dent of Hi	spanic Orig n, Mexican,	in? (Spec	city Yes or No lican, etc.)	- 1	14. Race - Ar Black, Wi	nerican Indian,	
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Maryland	s 1 and 2 should f Heelth and Mer Item 27 is marke other treumatic	H	19a. Informant's Name/Relationship HERMAN KLEIN, JF				LEEA!				'IMORE.	111000	21221		
ď.	s 1 and Heel		20a. Method of Disposition	tt / Drioznibit	20b. F	Place of Dispo	sition (Na	ne of			te et			or Town, State	
E 0	Page: nent o nnt: If nry or		13 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			CLAWN C				3/31/	2006	BAL	TIMORE	, MD	
Baltimore,	permit. Pages 1 Depertment of H Important: If Ite eny injury or ot once.		21. Signature of Euneral Service Lie	ensee		22	2. Name ar	nd Addres	s of Facility					HOME,	P.A.
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Box	death certific e attending pi id for use es t	Physician/Med	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Testania a					2	23d. Date of c	lelivery	
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Records,	law requires as been sign 2 should be	ete									24a. Was	an	24b. Were	autopsy findings	available
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<u>&gt;</u>	Physician: this certific ral director,	မ	1 Yes ≥ No	Hospitaf:		ER/Outpatier			4 (1901		e 5 🗆 Resi			oecify)	
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis of and manner st	of examina	owledge, deat ition and/or in	h occurred vestigation	at the tim	e, date and pinion, death	place, a h occurre	nd due to the d at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(	s)
	To ti To ti	Σ	29b. Signature and title of certifier	11.0	Λ A	Λ	29	c. License	number					onth, Day, Year)	. /
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5	)		30. Name and address of person wi	no completed cause of o	death (fter										
	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	rar's Signa	7601 atyre	4		RIVE	TOM	SON,	MARY	AL DND	21204	
	Registr		MAR 3 0	2006	1000 1	O. A	and is								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e, 20a 22 per 1h 9853 3-30-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Warch Beun **Physician** 9000 .37 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE Marylani
If Under 1 Year If Under 24 Hrd. 8. Date of Birth
Months Days Hours Min. Feb 24, 1 Secours HOSPI TAL 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F Maryland 86 Director 215-14-9744 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or iteme 23a or 28a-f show event, the Medical Examiner must be notified at 1
▼Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 827 N. Arlington Ave. 1000 N. Gilmore Street 21217 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black Completed by 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 0 janitor apartment complexes 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mentel Hy importent: If Item 27 is marked oth any lighty or other traumatic event QDGs. Be Shirley Nathaniel Beverly Esther Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 E. Lafayette Avenue Baltimore, MD 21202 Calvin M. Beverly/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 3-31-06 Owings Mills, Md. 5 MOther (Specify) in state 21. Signature of Euneral Service Licensee Konal S. Wale, Strang and Address of Sound F.H. 1101 E. North Ave 21201 21202 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Final disease or condition resulting in death) UROSEPS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires thet the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No efter death Director: / I in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge death oncurred at the time date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 29c. License number 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) BOLGIANO M 000 W 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2006

ORIGINAL

Amend item#11, perfit, 804, 4/4/ 60 11 Department of Health and Mental Hygiene 1 = For State Registrar Amend Item #1 Per Phy G854 Continues of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** DOMINI QUE 2006 Domonique Brice MARCH 22, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA BALTIMORE C.
If Under 1 Year If Under 24 Hrs. THE JOHNS PKINS PITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Hours 1 □ M 2 □ F Days 212-35-5868 Director 14 12-28-91 Md. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other then "natural", or items 23a or 28e-1 show event, the Medical Examples institled at 1X Yes 2 □ No Director Md. NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Gorsuch Avenue 21218 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 end 2 should be filed within 72 hours after if Heelth and Mental Hygiene. ☐Yes 2XNo 1 ☑ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student NA 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Domonic Brice Deirdre Pettaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deirdre Pettaway Mother 1605 Gorsuch Avenue, Baltimore, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: if ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park! 3-30-06 Arbutus, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 Wane & lady March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** TOXIC SHOCK SYNDROME resulting in death) /Medical Due to (or as a consequence of): Examiner AUREUS PNELMONIA STAPH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit PNEUMONIA INFINENCE that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ģ Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 📢 o 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DRGAN SYSTEM Completed 1 🗌 Yes 25 100 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has autopsy performe 1 ☐ Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 2 Accident М 1 Tes 2 No death in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge death oncurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ‡ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HES- 000 MARCH 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRADY 21287 MD WOLFE ST BALTIMORE Ν. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 11,18 per 1h 9854 4-14-06 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Ragistrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** March 23, LEWIS ADDISON BECK, JR. 2006 9:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 78 Murdock Road Baltimore County Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**☆** M 2□ F Months Director 218-07-7526 96 1909 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show 1 ☐ Yes 2√2 No Maryland Baltimore County Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code th and Mental Hygiene. 27 Ie marked other then "naturel", or Iteme 23a or : traumatic event, the Medical Examinar nital bein 21212 death v 78 Murdock Road USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 to Yes 2 □ No
If Yes, Give
Year or Dates: WWII TV Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Utility Company 5+ Accountant/Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lewis Addison Beck, Sr. Edith Gertrude Bel1 ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is eny injury or other tre once. 78 Murdock Road, Baltimore, Maryland 21212 Elizabeth Renwick (P.R.) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 3/31/2006 Pikesville, Maryland 21. Signatur Fune Al Serve Lidence away
Martin D. Lawson 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

10 W. Padonia Road, Baltimore, Maryland 21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): HEART disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Signiff 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certifice funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D2533/ MD. 3/23/2006

DHMH 17 Rev 1/2001

State Registrar

we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAI

7600 OS/ER

31. Date filed (Month, Day, Year)

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5011

32. Registrar's Signature

			•	•	d / Department of Health and M		
			_ State	state of Marylan	nd / Department of Health and N Certificate of Death		21115 119759
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. N	3 Time of Death
	Physicia		2 arhav	1 Crow	rwell		26 20069;85AM
j.	/Medic	al .	4. Facility Name (If not institution, give)str	eet and number)	4b. City, Town, or Location of Death		c. County of Death
	Examin	eı	Kuxton Health	+ Ke habili	tation tikesuille		Baltimore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If Under Year If Under 24 Hrs.	8. Date of Birth (Month Day, Year	9. Birthplace (State or Foreign Country)
0	Director	4	244-74-8425 101	1 2XF 60	Yrs.	6-4-199	75 /VC
	and	-	Usual Residence of Decedent  10a, State 10b. County	10c. Ci	ty, Town or Location		10d. Inside City Limits
	Maryl	Ď	NIS	P	Salfimore		1 ves 2 □ No
	r 28s	rec	10e. Street and Number	1 1	10f. Zip Code	10g. C	itizen of What Country?
	death with the Maryland ms 23a or 28a-f show rrivet be notified at	Funeral Director	6514 Eberle Di	r. Apt. 20	21215		USH
	ens ens	ner	11. Walkar States	. Was Decedent Ever in U Armed Forces?	<li>13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li>	pecify Yes or No- o Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 25 No Specify:		Specify: Back
21215-0036	within 72 hours after ene. than "natural", or Ite he Medical Extrinitie	ed	15. Decedent's Educa	ition	16a. Decedent's Usual Occupation	16b.	Kind of Business/Mustry
215	hin 72 an "na Med	pie	(Specify only highest grade   Etementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	xing	Docial 11
21	filed with Hygiene other tha	Completed	1240		Administrative	5	ecurity Ham.
Pu	d oth	Be	7. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maide	n Sumame)
y la	d Men narks natic	٦ ا	196 Informant's Name elationship (Type	2.S	19b. Mailing see ss (Street and Number of Ru	Mae K	or Youn, State, Zip Code)
Maryland	d 2 st th and t7 is r traur	1	Nathan L. Granu	11/11.00	I COLICI IX K	Himore,	MD 21215
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The file marked other than "natural", or thems 23a or 28a-f show tem 71 is marked other than "natural", or thems 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at		20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	ocation - City or Town, State
Baltimore	Pages ent of nt: If it ry or o		1 Burial 2 Cremation 3 Re Donation 5 Other (Specify)	moval from State	ruid Ridge 4-1	-2006 Yil	Kosville, OnD
alti	permit. Page Department of Important: If any injury or once.		21. Signature Fude al Same Lighns		Valua ddres of Faces re	ere Fine	ral Services
<u> </u>	Dep fmp gny		Jaugen C. St	elne	8728 Liberty Rd.		town, and 21133
		ķ.	23a. Part1. Enjer the disease, or complications, or heart failure. List only one			or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical	1	Immediate Cause (Final disease or condition resulting in death)		rotic acresionascul	ar Disec	2 SC
	Examiner			Due to (or as a conse	quence of):		
	Order of	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):		
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760,	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a conse-	quence of):		
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9 ×	ding se as	/Me	IF FEMALE: 23	c. If yes, outcome of pregr	nancy		23d. Date of delivery
Вох	leath cert attendin d for use	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fet 4☐Pregnant at time of			Month Day Year
o.	to the de by the tached	hys	9 Unknown	9□ Unknown			
S, P	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by P	-	-	sulting in the underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Donknown
of Vital Records,	w require been si shoufd I	ted	Decubitus 4100			-	
ec	law r	Completed	Dysphagia			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
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Zi.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:		ath (Check only one)  Home 5 Residence	C □Other (Specific)
ō	Phys r this gral di	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at	28d. Describe how in	
ion	nding Ph ath. r: After th e funeral	ation	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work?  M 1 Tyes 2 No		
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Ö	urs aft rel Di lled in						( North annual 1 1 2 2
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin one)	ician: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death occurred at the time, date and place nation and/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	of the of the comple	Mec	29b. Signature and title of certifier	and nation stated.	29c. License number	29d. [	Date signed (Month, Day, Year)
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_	ノ		Karro L. Babitt,	M.D., 25 N	em 23a) (Type, Print) AGIN Street, Suite 2000 nature	, Misterry	own MD 21136
	Sta Regist	ate	31. Date filed (Month, Day, Year)  MAR 3 0 200		M Angella		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) Day Month Vear **Physician** 10:05pm 27 March 2006 Jacqueline Crawley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 23, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday): **Funeral** Months 1 □ M 2X F 215-30-1377 PA 73 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 X No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21221 USA 78 Jinwood items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Never Married 2 ☐ Married ö 1 ☐ Yes 2 ▼ No Specify: Specify: White ģ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Franklin Square other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Secretary Hospital 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evone. is marked John Dean Shumaker Beulah Calloway ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven Crawley / son 1600 Alexis Drive Joppa MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore MD Bayview Crematory 3/29/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Won 'The Immediate Cause (Final CAMCER Physician ma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine inding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury s after dec. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and life of non ho completed cause of death (Item 2 a) (Type, Print) 30. Name and address 6701 N. Charles St. Balto. Mb ZIZOX

State Registrar 32 Registrar's Signature

2006

			For State Registrar	State of	Maryland		artment of I rtificate of		d Mental	Hygier	0007	09772
	Physici		Decedent's Name (First, Middle     Anthony		Cov	vingto	on		2. Date Mont	n. 1	Day Year 6 2006	3. Time of Death 06 45 AM
	/Medi Examir		4a. Facility Name (If not institution				4b. City, Town,				4c. County of Death	
	: Ermanat	Н	Union Memorial  5. Social Security Number		7. Age (In yrs. lasi	t birthdav)	Balt.	IMOre	rs. 8. Date	of Birth	NA 9. Birthr	place (State or Foreign
	Funeral Director		213-88-6922	M 2□F	42	Yrs.	Months Days	Hours N	lin. (Mont 5-	of Birth h, Day, Yea 23–63	ar) Coui	Md.
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation					10d. Inside City Limits
	h the Maryland r 28a-1 show	ō	Md.	NA			timore					1 ∑Yes 2 □ No
	deeth with the Maryland rms 23a or 28a-1 show r coust be codified at	lrec	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Cour	ntry?
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936	or its	Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 <b>%</b> No	1	Vas Decedent of I f Yes, specify Cub I □ Yes 2⁄□ No	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes Jerto Rican, etc	or No-	14. Race - Americ Black, White, Specify: B	
21215-0036	72 hours "natural", edical Exe	eted	15. Decedent (Specify only highes		1	6a. Deced	lent's Usual Occup kind of work done OO NOT use retire	ation during most of	working	16b.	Kind of Business/In	dustry
121	e filed within al Hygiene. I other then "	duc	Elementary/Secondary (0-12) 11th grade	College (1-	4or 5+)		00 NOT use retire al Estate				&V Realit	. Com
	Hygi other	S C	17. Father's Name (First, Middle, L	.ast)			ar Estate	-	Name (First, M			y Corp
ylar	2 should be and Mentel ris marked c	ToB	Alphonso		Coverda	ale		Shir	cley		Coving	ton
Maryland	d 2 should hand 7 is muttraum		19a. Informant's Name/Relationsh Janynee D. Cov		Wife		-				or Town, State, Zip Md. 21213	Code)
	ges 1 and 2 s t of Heelth ar If Itam 27 is or other trau		20a. Method of Disposition	/ Ing con	20b. Place	e of Dispos	sition (Name of	1	Date		Location - City or To	own, State
<b>E</b>	Pages nent of int: If I		1 🖾 Burial 2 □ Cremation  1 □ Donation 5 □ Other (Sp.				natory or other pla ills Cem		31-06	M	iddle Rive	er, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mentel Hygiene. Important: If Itam 27 is marked other than 'any fujury or other traumatic event, Illia Magnes.		21. Signature of Funeral Service L	icensee W C	(Land		Name and Addre	•	B 110	altimo	ore, Md. North Ave	21202
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that ca	used the death. I	Do not ente	er the mode of dyle	ng, such as card	liac or respirate	ory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Myo	cardio	al	INFar	ction				Onset and Death
	/Medical Examiner		resulting in death)	Dug to (c	or as a consequen	ce of):	\					
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequen	ce of):	rrery	N/3	ease			o years
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8760,	cate be executed physicien and the burial-transit	ai Ex	resulting in death) Last	Due to (d	or as a consequen	ce of):						
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Вох	The law requires that the death certifi site has been signed by the ettending page 2 should be deteched for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 ☐ Fetal de		Ectopic pregnanc	,			23d. Date of delive	*
O. E	the ett	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		int at time of death		Other (specify)		-	-	Month	Day Year
P.O.	that If		Part II. Other significant condition	ns contributing to dea	ath but not resultin	g in the un	derlying cause giv	en in Part I.	23e.	Did tobacco	use contribute to th	ne cause of death?
Records,	w requires been sign should be	ed by							_	1 □ Yes	2 No 3 □ Prob	abiy 4 ∐Unknown
900	law requias been 2 should	Completed								Masan autopsy	24b. Were autop	osy findings available impletion of cause of
<u>E</u>		Cod								erformed?	death?	
of Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	- Wes	(0.1	Oth	or	Death (Check o			
10	ding Phys th. After this funeral di	T.	27. Manner of Death	28a. Date of		Outpatient	3 □ DOA □ 28c. Injur Wor	4   Nursing			6 □Other (Specify ury occurred	")
Sor	Attanding ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investige	ation	, Day 16ai)	Injury		Yes 2□No				
Division	or Attancation death after death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 288. Place	of Injury - At home g, etc. (Specify)	, farm, stre	et, factory, office		28f. Locati City of	on (Street a r Town, Sta	and Number or Rura te)	Route Number,
_	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying	Physician: To the t	pest of my knowled	dge, death	occurred at the tir	ne, date and pla	ice, and due to	the cause(	s) and manner as st	ated.
	the Ho in 24 l the Fu	edicai	(Check only 2 Medical E	xeminer: On the bas and manne	sis of examination	and/or inv	estigation, in my o	pinion, death oc	curred at the ti	me, date ar	nd place, and due to	the cause(s)
	or with a second	Σ	29b. Signature and title of certifier	- N	D		29c. Licens		-	1.	ate signed (Month, L	
	<b>/</b>	-	20 Name and address	M.		a) (**		5337		Ma		2006
	3		30. Name and address of person w		of death (Item 23)			Bal	timore	Mar	yland 21	218
7	Sta	ie.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature					-	<del>:</del>	
	Registr	ar	MAR 3 0 20	106	8.00 JES. J.	The same of						

			For State Registrar	State of	Marylar		artmen			ind M	ental Hy	giene	U U	6 (	9773	
	Physici		1. Decedent's Name (First, Middle, I	ast)	Her	JR					2. Date of Dea			Year	3. Time of Death	M
	/Medic Examin		4a. Facility Name (If not institution, g  Montgomery Gene	ral Hospi	tal		01	ney	Location of	f Death				of Death	ry	
*	Funeral Director		5. Social Security Number 220-60-7345  Usual Residence of Decedent	Sex 7	. Age (In yrs.	. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan 22)	v. Year)	54	9 Birthp Coun Mary	lace (State or Forei try) 1and	gn
ne Maryland	Ba-f ehow	Director	10a. State 10b. County Maryland Montgo	mery		ity, Town or Lo								1	0d. Inside City Limit	
ath with th	23a or 2 ust by no		10e. Street and Number 14004 Castaway	Drive			10f. Zip	Code 2085	3			10g. Cit		What Coun	try?	
<b>-0036</b> hours after death with the Maryland	giene. r than "natural", or lteme 23a or 28a-f ehow tta Medical Evanti at mentitat by notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? X No	1	Was Deced f Yes, spec 1 ☐ Yes 2	offy Cuba	spanic Orig n, Mexican, Specify:	jin? (Spec Puerto P	cify Yes or No- lican, etc.)			e - Americ ck, White,	etc.	
1215- within 72	r than "na It a Medic	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education trade completed) College (1-4 5+		16a. Deced (Give life.	kind of wor DO NOT us	rk doné d se retired	luring most )		g	Nat			dustry stitutes	
ਰ ਵੱ	nt of Health and Mental Hygis: If Item 27 is marked other or other traumatic event, II	To Be C	17. Father's Name (First, Middle, La.  Charles Stanley	Carter,	Sr.	4				Marj	(First, Middle.	Bu	rdet	te		
40 %	of Health and Item 27 is n other traun		19a. Informant's Name/Relationship  Laura B. Carter  20a. Method of Disposition		206		4 Cas	tawa		ve,	Route Number Rockvil	lle,	Maı	ryland	1 20853	
altimore,	rtant		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	ate (	cemetery, cren klawn	natory or of Memor	ial	Park	4/01				City or To	wn, State aryland	
Ba Perman	Depa Impo Impo	94	23a. Part. Enter the disease, or co	Hillia	ms)	Мо 26	leswo 401 R	rth- idge	_Road	ams Dat	P.A., E	Ma	ral ryla	Home and	20872 Approximate	_
} " R	ysician Medical Medical taminer	dical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that iniliated events resulting in death) Last	a. Or Or Due to (or Due to (or c. 12	as a consecutive as a c	quence of):	ery	rt v	ricit	ese sed	e S	631,			Interval Between Onset and Death	
O. Box 6.	ed by the attending phy detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 □ Feta it at time of c	al death 3	Ectopic pre						23d. Dat Mor	e of deliver	ry Day Year	
ords, P	e d p e d	þ	Part II. Other significant conditions	contributing to deat	th bul not res	sulting in the ur	iderlying ca	use give	n in Part I.			bacco u es 2[		ibute to the	e cause of death?	n
	ate has page 2	e Completed									24a. Was a autops perform	y .	P	rior to com leath?	isy findings available pletion of cause of 2 No	е
of Vital Physician: T		o B	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inp	etiont A	ER/Outpatien		Othe	_		Check only on					=
JIVISION OF or Attending Phy	ath. r: After this e funeral di	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of (Month,		28b. Time of Injury		Bc. Injury Work		28	e 5 Reside				)	-
DIVIS	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of building	, etc. (Specil						City or Town	n, State,	)		Route Number,	
DI To the Hospital or	within 24 hours  To the Funeral  completely filled	ledical	one)	hysician: To the be miner: On the basi and manner	s or examina	owledge, death ition and/or inv	occurred a estigation,	it the time in my op	e, date and inion, death	place, an occurred	d due to the ca	ause(s) ate and	and mai	nner as sta and due to	ited. the cause(s)	
7	To	Σ	29b. Signature and title of certifier  Emerce	encylle	dicine	Physic	190.	License	number 3607	17	N	9d. Dat	e signed	28	Pay, Year)	
	177		30. Name and ddress of seven who	8101 Prin	4Phil	n 23a) (Type, 1	rint)	nev	Mo	ryli	and 2	30	32	_		
	Stat	100	31. Date filed (Month, Day, Year)  MAR 3 0 201	49	istrar's Signa	ature Age	KI		•	,						

		Please I	State of Mandan				_	_	
		1 - For State	State of Marylar	•	nent of F icate of I			The state of	
		Registrar  1. Decedent's Name (First, Middle, Last)		Cerun	icate or i	Dealli	2. Date of Deat	g. Nø. () () (	3. Time of Death
Physic /Medi		Frances Davis	S				Month	2710 2001	11:20
Exami		4a. Facility Name (If not institution, give s	street and number)	4b	. City, Town, or	Location of Deat	h	4c. County of Dea	
	W.	Mercy Medical	(enter		Bal	h more,		Balhm	
Funeral Director		5. Social Security Number 6. Sex 1 -	7. Age (In yrs.		Under 1 Year onths Days	Il Under 24 Hrs Hours Min.		Year) 9. Bit	thplace (State or Foreign ountry)
land wo		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Localic	on				10d. Inside City Limits
office death with the Marylan ritems 23s or 28s-1 show therefore the motified at	tor	MO NA	BAL	TIMORE					1 X Yes 2 □ No
th the	Director	10e. Street and Number		1	Of. Zip Code		1	0g. Citizen of What C	ountry?
23a 23a	a	904 WILDWOOD P	'ARKWAY		212			LISA	
after dea	Funeral		12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was	Decedent of H is, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
5-UU36 72 hours after death with the Maryland netural; or items 23a or 28s-1 show used Exaculted from the modified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>M</b> No If Yes, Give Year or Dates:	1 🗆	Yes 2 No	Specify:		Specify: B	ACK
Z15-0036 ithin 72 hours af te. on "natural", or Medical Expen	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent'	's Usual Occup	ation during most of wo	rking	16b. Kind of Business	/Industry
within she.	g	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	MAKE			DOMES	110.
N 5 5 5	ပိ	8/H GRADE 17. Father's Name (First, Middle, Last)	NA	1 HOILIP	THATCE		me (First, Middle, M	Maiden Sumame) UN	
Manual Ked C	To Be	JOSEPH SOLMHERI	AND			PAULINE			
Maryla Id 2 should Ith and Men Ith and Men Ith and Items Treumatic		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing A	ddress (Street			City or Town, State,	Zip Code)
	1	DARLINE MOORE	20h		DAR CHI		ALTO. MI	21234 20c. Location - City of	Town Slate
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	Place of Dispositio cemetery, cremato	ory or other plac				
Baltimo permit. Page Depertment Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lice ■		DAR HILL	ame and Addre	es of Facility		BALTIMORE	MD
Depentit. Depentitions in point any in point.		Vaushn ()		VAUG	HN C. G	IREENE FU	WERAL SEA BAITO, MO	21229	
ACCOUNT.		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not enter th	ne mode of dyin	g, such as cardia	c or respiratory arri	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Dlewal	Effici	nn				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	quence ol):					0.0
LAMITIME	_	Sequentially list conditions if any, leading to immediate	Due to (or as a conse	mance off:		arvo-			2-3years
hetu l	Examiner	Cause (Disease or injury	SUDENCY		uva -	simlin	me_		month
760, 160 be executed ysician and he burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	quence of):	-(XVI)	Syriaio	VIL		
58760 icate be e physiciar s the buri	lical		1						
Box 687 leath certificate ettending phy.	/Mec	IF FEMALE:	3c. If yes, outcome of pregn	nancy				23d. Date of de	alivon.
BOX leath cert ettendin for use	clan	in the past 12 months?	1 Live birth 2 Fet	al death 3 □Ect	opic pregnancy her (specify)	/		Month Month	Day Year
P.O. I	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				_		
COTGS, P	ρ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the under	rlying cause giv	en in Part I.	23e. Did tol		to the cause of death?  Probably 4 Unknown
Orc requi	eted	- CURTHAL				<u> </u>	24a. Was a		
	Completed	1					autops perform	y prior to ped? death?	succession of cause of successions and succession of cause of successions are successions.
of Vital Re hysician: The la his certificate he: I director, page 2	(a)	25. Was case referred to medical			-	26. Place of De	1 ☐ Yes		5 22,NU
1 V	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 hopatient 2	ER/Outpatient	3□ DOA Oth	er: 4 Nursing	Home 5 ☐ Reside	ence 6 □Other (Sp	ecify)
on of ding Phy h. After thi funeral of		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	ow injury occurred	
isio	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I			Yes 2 □No	28I, Location (S	treet and Number or F	Rural Route Number.
Div	Certification:	4 Homicide determined	building, etc. (Spec	rify)	tuoiory, amoc		City or Town		
Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death oc nation and/or invest	curred at the til	me, date and place	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
To the within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mor	
		D Julinen			1719	123		3/27	106
10		30. Name and address of person who co		om 23a) (Type, Prim	Vale.	, Balti	nove M	0 2120	12
36.75	ate	31. Date liled (Month, Day, Year)	32. Segistrar's Sign	natura Log	de	1	1		
Regist	trar	MAR 3 0 2	UUD ARMEN	-					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Month 27 **Physician** 2006 400AM /Medical (If not institution, give street and number) 4h City, Town or Location of Death **Examiner** more If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Director Usual Residence of Deceden with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits : if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Funeral Director move 10e. Street and Jumber 10f. Zip Code 10g. Citizen of What Country? 21216 trenu Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Race -11. Marital Status 1 Pes 2 No If Yes, Give Year or Dates: 2 Marned 1 Never Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work there during life. DO NOT us ritired) 16b. Kind of Business/Industry Elementary/Speonda 0-12) College (1-4or 5+) if Health and Mental Hygie item 27 te marked other 18 Mother's Name (First Middle, Maiden Sumame) ather's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental PSON ames nt's Name/Relationship (Type, Hrint) 19b. Mailing Address (Street and Numbe City or Town, State, Zip Code) ethod of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State important: If any Injury or once. 21. Signature of Fundral Service Licensee 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ch as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Lun Cahcer **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed i Director: After this certificate has been signed by the ettending physicien and d in by the tuneral director, page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Nieca Other: 4 Nursing Home 5 Residence 6 ther (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifies 3/23/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Ste#340 23 ont 3 Crussroads 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State of Maryla		artment of rtificate of		R	eg. No. UU 6	9776
,	Physici		1. Decedent's Name (First, Middle, Last, Myrtle R. Da					2. Date of Dear Month MArch	Day 2006	3. Time of Death
	/Medic	5.	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	1	4c. County of Death	1
1			Franklin Squa	re Hospita	1		edale		Baltimore	e
	Funeral Director		5. Social Security Number 6. Sec. 214-24-0009	7	s. last birthday) 78 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day March	9. Birthp 27, 1928	lace (State or Foreign try) NC
	Aaryland Febow	ō	10a. State 10b. County MD Baltimo		City, Town or Lo	cation e River			1	0d. Inside City Limits 1 ☐ Yes 2X No
	with the P s or 28a- be notifi	Funeral Director	10e. Street and Number 1116 Stephen D	rivo		10f. Zip Code 212	120		Og. Citizen of What Coun	try?
	eath ve 23	eral	11. Marital Status	12. Was Decedent Ever in	118 13				SA 14. Race - Americ	an Indian
036	d within 72 hours after death with the Maryland jiene. r than "naturel", or Itame 23a or 28a-f ehow The Madical Examinar mult be naiffiad at	by	1 Never Married 2 Married 3 🔀 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert Specify:	o Rican, etc.)	Black, White,	etc.
15-0	"natur	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	-	16b. Kind of Business/Inc	tustry
212	d within giene. er then "	omo	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		memaker	,		own home	
Maryland 21215-0036	t be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last) W.M.L. Miller					ne (First, Middle, i	Maiden Sumame)	
Ž	should be and Mental marked umaric ev	T <sub>o</sub>	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailir	na Address (Stree	unknov		r, City or Town, State, Zip	Code)
	nd 2 alth ar 27 le		John Davis Jr.	/ son					e MD 21220	•
Baltimore,	Pages 1 and 2 should nent of Health and Mer ant: If Item 27 le marke ury or other traumatic		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Dispo	sition (Name of natory or other pla		Date	20c. Location - City or To Baltimore	
Balt	permit. Pages Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licens	y Conne	/1 //	Name and Addr		00 Mace l Home	Ave. Balt of Essex 2	O. MD
8760,	Physician / Medical bullian funding the parial-fransit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	fahc equence of):		small Le			Approximate friterial Between Onset and Death
P.O. Box 68	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c, ff yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date of delive Month	ry Day Year
	Se De	by	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	nderlying cause g	ven in Part I.		bacco use contribute to thes 2 □ No 3 □ Prob	
I Records,	The ate h page	Completed						24a. Was a autops perforr	sy prior to cor med? death?	osy findings available npletion of cause of
Vital	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	A				th (Check only on	10)	
of	Phys rthis raldir	٠ <u>۲</u>	1 Yes 2 No	lospital: 1 X Inpatient 2	☐ ER/Outpatier 28b. Time of	1 3 DOA			ence 6 Other (Specify ow injury occurred	')
ion	Attending Physicien: r death. sctor: After this certific. by the funeral director.	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	fnjury	We	ork? Yes 2 No	200. 0000.00 110	ow injury coccincu	
Division	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or Rura n. State)	l Route Number,
	ne Hospital n 24 hours a ne Funerel I	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deati nation and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the corred at the time, d	ause(s) and manner as st ate and place, and due to	ated. the cause(s)
	To the within 2	ŭ	29b. Signature and title of certifier	0000010	1117	29c. Licen	se number	2	9d. Date signed (Month, 1	Day, Year)
1	4			ice and	MD	Die	1 > 53		> 24-	2006
2	)		30. Name and address of person who co Sankani Siva	Sailam	om 23a) (Type,	ladelph	19 Ry	Suitedo	3 - 29 8 Balto Ma	1.21237
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 3 0 20	Jz. Mogistiai s Jig	nature	and it				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** March 26 2006 9:35pm John J. Dolan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverview Nursing Center Essex Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 13, 1914 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⋈** M 2□ F Illinois 91 Yrs. Director 252-07-5854 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other treumatic event. The Madical Examinar must be notified at MD Baltimore 1 ☐ Yes 2X No Director Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 10 Helena Ave. 21221 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Beth Steel Elementary/Secondary (0-12) Cottege (1-4or 5+) Industrial Engineer 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John F. Dolan JosephineConnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other treum once. Katherine Skupas /daughter 21502 12315 Henry Drive Lavale MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 3/31/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or combications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Finaf **Physician** Honoll disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ardio ~ Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Physician/Medical Examiner physicien and s the burial-transit The law requires that the death certificate be executed renter Due to (o = a consequence of) Division of Vital Records, P.O. Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day į Month Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has 1 Yes 2 No Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sebastion John 29/06 0 00551 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Baltimore 3023 Avenue Caster 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 3 0 2006 Registrar

			1 - For State Registrar	State of Marylar	•	rtment of H		ntal Hygie		19//8	
-	Physici /Medio			ATHERINE	DA'	res		Date of Death Month ARCH	27 2006°	3. Time of Death 2:00 рм	
1-	Examin		4a. Facility Name (If not institution, give str 19 CUNNING COUR!				Location of Death		4c. County of Death BALTIMO		
Œ.	Funeral Director		210 40 0726	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Y UNE 3	9. Birth Col 1943 MAR	pplace (State or Foreign untry) YLAND	
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMOR		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the 23s or 28s	Funeral Director	10e. Street and Number 19 CUNNING COUR	<b>T</b>		10f. Zip Code 2122	20	10g	. Citizen of What Co	untry?	
036	urs after deal el', or iteme	þ	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🖾 No	ispanic Origin? (Specin, Mexican, Puerto Ric Specify:	ly Yes or No- can, etc.)	14. Race - Amer Black, White Specify: WH	e, etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neture!; or iteme 23s or 28s-f show other traumatic event, the Mudical Exeminer traumatic event, the Mudical Exeminer traumatic	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	during most of working )	16	b. Kind of Business/I	,	
and		Be	17. Father's Name (First, Middle, Last)  WILFRED F. F	OLEY		JORRELL	18. Mother's Name (i		iden Sumame)		
Maryland	should I	70	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a	and Number or Rural F		ACHOVIC  City or Town, State, 2	lip Code)	
ď.	ages 1 and 2 nt of Health a t: If Item 27 is r or other tra		JOHN L. DATES /  20a. Method of Disposition  Depurial 2 Cremation 3 Rev	20b. I	Place of Dispo	sition (Name of natory or other place	COURT MI  Date   3/31/	9 20	IVER, MD	Town, State	
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny Injury or ot		4 □ Donation 5 □ Other (Specify)  21. Signature of Fig. 1 Service (icensee		22	. Name and Addres		CH/ROS	ALTIMORE EDALE FU IMORE, M	NERAL HOM	
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consect	guence of):	er the mode of dyin	g, such as cardiac or n	espiratory arresi		Approximate Interval Between Onset and Death  World	
P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	edicai	Physician/Medicai Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9.20 Unknown	Due to (or as a consect to the conse	ancy	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	quires that n signed by uld be deta	þ	Part II. Other significant conditions contr	ibuting to death but not res	sulting in the u	nderlying cause give	an in Part I.	1.7	cco use contribute to	the cause of death?	
Vital Records,	The ate h page	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of	
Vita	Physiclan: r this certificated director, it	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	spital:	ER/Outpatien	it 3□ DOA Oth	26. Place of Death	- 1	ce 6 □Other (Spec		
sion of	ding h. Afte tune		27. Manner of Death  ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		d. Describe how		луу	
Division	o Hospital or Atten 24 hours after deat Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town,			
	the Hospital hin 24 hours a the Funeral I npletely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r: On the best of my kn r: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, an pinion, death occurred	d due to the cau at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)	
)	To the within To the comple	Σ	29b. Signature and fittle of certifier			29c. Licens	15475	3	Date signed (Monti	n, Dey, Year)	
			30. Name and address of person who com	pleted cause of death (Ite			Darme	MD :	21234		
×	Sta Regist		31. Date filed (Month, Day, Year)  MAR 3 0 2	32. Redistrar's Sign	ature	pode	<del>BALTIMORI</del>	5,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** John P. D'Angelo March 25, 2006 7:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** Calvert County Asbury-Solomons Health Care Center Solomons If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 27, 1920 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 721 01 9308 85 Vrs Sept Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 7 is marked other than "natural", or Iteme 23a or 28a-f show traumatic avent, the Medical Examination must be notified at 1 Yes 2 No Maryland Calvert Solomons Directo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 11450 Asbury Circle 20688 Funerai 12. Was Decedent Ever in U.S. Armed Forces? → ☑ Yes 2 ☐ No → 1 A Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours after if Hygiene. other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: ₩Widowed 4 Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medica1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic avent ones. Catherine McLees Benedict D'Angelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 1470 Solomons, Maryland 20688 John Benish (Per Rep.) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mairch 30,2006 20c. Location - City or Town, State 20a, Method of Disposition

A D Burial 2 Cremation 3 Removal from State Resurrection Cemetery Clinton, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 663301d 21. Signature of Funeral Service Licenses Alexandria Ferry Rd, Clinton, MD 20735 400153 flet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TROKE WEEKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THEROSCUERATIC CARDIOVASCULAR DISTAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FRTFNSIN 1 Yes 2 No 3 Probably 4 Unknown should peed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has tor: After this certific the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 726358 March 28, 2006 541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10845 Town Center Blvd., Dunkirk, Maryland 20754 John A. Weigel, M.D. 31. Date filed (Month, Day, Year) MAR 3 0 2006 32. Registrar Signature State Registrar

			For State Registrar				d / Depa		t of H	ealth a		lental Hy		nns	0978	30
	1 to 1		1. Decedent's Name (First, Middle,	Last)								2. Date of De Month	ath Day	y Year	3. Time of	Death
	Physici /Medic		MARIE MICHELE D	iAIS0								3	28	2006	1:10	A M
	Examir		4a. Facility Name (If not institution,	give street ar	nd number	)		4b. City,	Town, or	Location of	f Death			County of Deat		
			VILLA ROSEA					BOWII	Ξ				AN	NNE ARUN	DEL	
	Funeral Director		140-01-6200	6. Sex 1 ☐ M 2X		ge (In yrs. I 92	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Pa 10/08/1	1913	9. Bin NEW	hplace (State of JERSEY	or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Mary 1 sho	2	MD PRINCE	GEORG	ES	BOW	IE								1 ☐ Yes	2 🛣 No
	28a	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of What Co	untry?	
	3a or	<u>a</u>	LOTTA VISA ROAL	)				207	721				U.S	S.A.		
30	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23e or 28e-1 show event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marrie  3 □ Widowed 4 □ Divorced	12. Was	Decedent ed Forces Yes 2 Des, Give r or Dates	(No		Was Deced If Yes, spec			gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whit Specify: WHI	e, etc.	
Maryland 21215-0036	ithin 72 hou ne. nan *nature nan *nature	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	grade comple	<i>eted)</i> ege (1-40)	5+)	16a. Dece (Give life.		al Occupa rk done d se retired	ation luring mosi )	t of work	ing		ind of Business/	Industry	
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yland	should be filed ind Mental Hygid s marked other umatic event, ii	To Be	17. Father's Name (First, Middle, L WILLIAM SARNO	.ast)						MIN	NIE	SERENO				
ā	2 m m 0		19a. Informant's Name/Relationsh		t)									or Town, State, 2	Zip Code)	
	iealth im 27 her tr		ROBERT DIAISO -	- SON		20h P	1					OFTON,		21114 ocation - City or	Town State	
0	(1) () may be	-	20a. Method of Disposition 1 △ Burial 2 ☐ Cremation	3 □Removal	from Stat	9	lace of Dispo emetery, crea									
Baltimore,	t. Pa rtmer rtent njury		4 □ Donation 5 □ Other (Sp. 21. Signature of paral Service I			HOL	Y NAM			-		2006		SEY CITY ERAL HOM		
eg M	permit. Page Department Importent: It any injury o		To V		60 a .	. 9.75								IKAL HOM		
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	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ue to (or a	s a consequence of the consequen	uence of):	- Ca	non	ova	SCI	ilan D	1150	cen	Jean	18
68760	a % a	cal		d												
Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate be exwithin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician completely tilled in by the funeral director, page 2 should be detached for use as the burial	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	10	Live birth	e of pregna 2  Fetal at time of de	death 3	⊒Ectopic pr ] Dther <i>(sp</i>						23d. Date of de Month	,	Year
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Reco	The law re- ite has bee bage 2 sho	Completed										24a. Was auto perfe 1  Yes		prior to death?	utopsy findings completion of c	available cause of
<u>ta</u>	ien: rtifica ctor, I	Be	25. Was case referred to medical examiner?							26. Place	of Dea	th Check only	1			
<u>~</u>	hysic nis ce I dire	2	1 ☐ Yes 20 No	Hospital:	1 🗌 Inpa	tient 2 🗆	ER/Outpatie	nt 3 DC	Oth Oth	Br: 4 NL	ursing H	ome 5 🗆 Resi	idence	6 ☐Other (Spe	city)	
o uo	nding Pt ath. r: After tt ie funeral		27. Manner of Death  1 Adatural 5 Pendin- 2 Accident investig		Date of In (Month, D	jury Ja <i>y Year)</i>	28b. Time o Injury	f 2	8c. Injun Worl 1 □	yat k? Yes 2□	No	28d. Describe	how inju	ry occurred		
Divis	al or Atters all Directord in by the	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		Place of I building,	njury - At ho etc. <i>(Specif</i> )	ome, farm, st	reet, factor	, office			28f. Location ( City or To		nd Number or R e)	ural Route Nun	nber,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (		Examiner: On		of examina								and manner as d place, and due		s)
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	20		RAKESH ARC	who complete	d cause o	death (Item	1 23a) (Турв ОБАЦС	Print) ANT	Fox	LN	#2	22 Boi	WIL	E MD2	0715	
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		1		epartment of Health and Mental Fortificate of Death	Hygiene Reg. No. 0 0 6	09781
			1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year	3. Time of Death
	Physicia /Medic	al -	CYNTHIA HARRINGTON DWYER		4c. County of Death	
	Examin	er j	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Baltimore	N/A	
- 10 A	Funeral		Roland Park Place  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	taul If Under 1 Year   If Under 24 Hrs.   8 Date of	Birth 9. Birth	nplace (State or Foreign
	Director	1	182-42-5882 <sup>1□M</sup> <del>XX</del> F 87 Yrs	s. Months Days Hours Min. Septer	mber 17, $1918$	New York
	pug *	<b>⊢</b>	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	or Location		10d. Inside City Limits
	Manyla f sho	ō	Pennsylvania Bucks Newtow	n		1 ☐ Yes XX No
	sa or 28a	Funeral Director	10e. Street and Number 7 Buckman Drive	10f. Zip Code 18940	10g. Citizen of What Cou USA	untry?
136	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Items 23a or 28a-f show uth: Ita Mydrol Evalor or must be notified at	b	11. Marital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Amed Forces?  1 XXes 2 □ No WW I I  If Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> <li>1 ☐ Yes 2 XXo Specify:</li> </ul>	r No- ) 14. Race - Amer Black, White Specify:	
Š	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b. Kind of Business/l	Industry
21	nithin ne.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)  Homemaker	Own	Home
Maryland 21215-0036	I be filed v ntal Hygie ed othar t avant, th	Be	17. Father's Name (First, Middle, Last) Charles Andrew Harrington	18. Mother's Name (First, Min Maybel Mann	ddle, Maiden Sumame)	
Maryl	d 2 should be th and Mental 7 Is marked of traumatic av	F	19a, Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rural Route No Buckman Drive Newtown, Pe		
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show miportant: If item 27 is marked other then "natural", or Items 25e or 28e-f show miportant: If item Medical Examiner must be notified at ONCE.		20a. Method of Disposition  1	Disposition (Name of crematory or other place)  PDCUICHTE Cem. 4/8/06  22. Name and Address of Facility Mitchell-W	Philadelphi Viedefeld Funeral	<sub>Town, State</sub> a, Pennsylvania Home Inc
	<u>205</u>		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one caus: n each line.		Baltimore, Maryl	Approximate Interval Between Quiset and Death
68760, 7	/Medical Examiner but sician and the prijar-transit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseque	metine hung chaether	<b>&gt;</b>	Years.
P.O. Box 68	death certiti e attending ed tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of del Month	livery Day Year
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)	To the within 2 To the complete	Med	29b. Signature and title of certifier  ▶ That elle Tac Gregor 17)	29c. License number D 13 6 5 7	29d. Date signed (Month Tarch 28)	
	$\sigma$		30. Name and address of person who completed cause of death (ftem 23a) (7). ISABELLE MAERREGIR, 700 L	Type, Print) W STREET, BALTI	nore, orda,	1211
		ate	21 Data filed (Month Day Year) 32 Pedistrar's Signature			
D	Regist	*	MAR 3 0 2006 Beens &	BOSAGE .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** March 27,2006 Esther Ellis 2:15P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health at Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2**X**□ F 78 Yrs. March 20,1928 MD. Director 218-22-8386 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State 289-f show other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 🏖 No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 21060 U.S.A. 7523 Baltimore Annapolis Blvd. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Co:/ Book Binder Packer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic manner. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ollie Florence Eastridge Alton Lester Cosner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter in Mrs.Betty Jane Kirby 7523 Baltimore Annapolis Blvd Glen Burnie, MD.21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March 30 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2006 Glen Burnie, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moi357 1 Second Avenue S.W. GLen Burnie, MD.21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. an Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FAILURE /Medical Due to (or as a consequence of) Examiner DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit EMPHYSEMA Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2 NO Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ⊟Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending & within 24 hours after death.
To the Funerel Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18426 PATALINGHUG SVIND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 POTEC ST. CARLOS N. PATACINEHUG SRAND

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

			State of Maryland / D. State of Maryland / D. Amend Items 23a, PtI, 23b, e, 25	epartment of Health and N	dental Hygie G853,03/2	ene 28/06dhb	9783
	· Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day 200 Year	. Time of Death
	/Medic		Janice Kay Grubbs Flaherty	th City Town or Location of Dooth		Day 2006 2	1:26 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Carroll Hospital Center	4b. City, Town, or Location of Death Westminster		Carrol1	
M.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Q Richalace	State or Foreign
	Director		235-84-1757 10M 2XF 54 Y	rs. Months Days Hours Min.	Apr 4, 1	951 WV	
ī	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d.	Inside City Limits
	Maryla f sho	ō	MD Carroll	Sykesville		Calizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry  Clerical  en Sumame)  IS  y or Town, State, Zip Code)  21784  Location - City or Town, State  Resville, MD  (Box 195)  95-14:00  Approximate Interval Between Onset and Death  CAL EXAMINER  23d. Date of delivery Month Day Year  co use contribute to the cause of death?  2 □ No 3 □ Probably 4 ▼Unknown  24b. Were autopsy findings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?	
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	h with	al D	6117 Emerald Lane	21784		USA	
	ems ems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
30	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No If Yes, Give <sup>A</sup> 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 21 No Specify:		Specify: Whit	:e
3	72 hours after death with the Maryland neturel', or items 23s or 28s-f show alcal Exertliner mast be notified at	ed b	15. Decedent's Education 16a. [	Decedent's Usual Occupation	16	16b. Kind of Business/Industry	
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D	T 12 D 0	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma L. Jenki		
3	should be ind Mental marked o	L <sub>0</sub>	Banjamin E. Grubbs, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or Ru			de)
Maryland	nd 2 salth an 27 is r			.7 Emerald Lane Syke			
	a He He		20a. Method of Disposition 20b. Place of competency				State
Baltimore,	Pages nent of ant: If i			inty Cremation 3/7	/06 S	Sykesville, M	ID
alt	permit. Pages: Department of I- Importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee	HAIGHT FUNERAL HOM	E & CHAPE	EL (Box 195)	
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Funeral		5. Social Security Number	6. Sex 7 1  M 2  F	Age (In yrs. last birti	Months	1 Year Days	If Under Hours	Min.	B. Date of Bi (Month, Da	rth ay, Year)	9. Birth	place (State o intry)	or Foreig
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pc ≱		Usual Residence of Decedent  10a. State 10b. Count	,	10c. City, Town	or Location							10d. Inside C	ity Limit
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7		C. VERGADA -	SPARFC C	2200 PROI	ESSIONA	L 7	PLACE	LAN	DOVER	MD	207	35	
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State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2006 Physician 8:20 PM Fitzgerald Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery General Hospital Montgomerv | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | March | 23 1952 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1 □ M 2 🖾 F 54 188-42-0066 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b Counts 10c. City, Town or Location 10a State or 28a-f ehow sust be notified at 1 ☐ Yes 2 X No Germantown Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 USA 18011 Cottage Garden Dr., Apt. 303 238 Funerai fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examinent 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Pharmaceutical Co. Clinical Safety Manager other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic avent once. Be Rodger Fitzgerald Greene ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4710 Springfield Ave., Philadelphia, PA 19143 Kathryn E. Edmondson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition April 01 1 □XBurial 2 □ Cremation 3 □ Removal from State Springfield, PA SS. Peter & Paul Cem. 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications to cause shock, or heart failure. List only one cause in each lire. Immediate Cause (Final remoplyors Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence 1) Examiner been signed by the attending physicien and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 1 No 2 1 No 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 THO 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after dea To the Funeral Directon completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Prime Phillip Pr Unes, Mb 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) (8/CI LOVENZO Heather 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3 0 2006

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	Funeral Director		5. Social Security Number 6. Security Number 217-25-7811	7. Age (In yi	S. last birthday) Yrs.		Year If Under Pays Hours		of Birth 10, Day, Yea 3, 1962	2 5	9. Birthp Coun	ace (State or I	Foreign
	death with the Maryland me 23e or 28e-f ehow rmust be notified at	ector	MD BALTIMO		City, Town or Lo				10-6			od. Inside City 1 ☐ Yes 2	
98	after death with or iteme 23e or aminer must be	Completed by Funeral Director	7 SQUIRE COURT  11. Marital Status 1 Never Married 200 Married	12. Was Decedent Ever in Armed Forces? 1			21 t of Hispanic Orig Cuban, Mexican	136 gin? (Specify Yes Puerto Rican, et	_			USA an Indian,	
21215-0036	d within 72 hours piene. r then "naturel", the Wedical Em	ompleted by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)  Elementary/Secondary (0-12) 12	Year or Dates:	16a. Dece	dent's Usual O kind of work d DO NOT use re	ccupation	of working		Specify: Kind of Busin	ness/Ind		
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) I SAAK		FLEYT	MAN		r's Name <i>(First, M</i> LIZABETH	Aiddle, Maide			ZELDI	NA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or iteme 23e or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at ance.		19a. Informant's Name/Relationship (Ty, ANZHELIKA FLEYT)	MAN / WIFE	7 S	QUIRE C	OURT -	r or Rural Route I REISTERS				Code)	
Baltimore,			20a. Method of Disposition  1 ፟ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State		HEBREW	CEM. 0	Date 3/29/200	6 RE	Location - Cit ISTERS	TOWN	, MD	
Bal	Depermit Import eny in		21. Signature of Funeral Service License	itter		3900 RE		OWN ROAD	- PIk			MD 212	08
	/Medical Examiner and physician and the buriel-transit the buriel-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	VRIE		3 (3 (3 (3 (3 (3 (3 (3 (3 (3 (3 (3 (3 (3	ory arrost,			Approximate Interval Betwee Onset and Dea	en ath
.O. Box 6	The law requires thet the death certificate be executed to has been signed by the attending physician and lage is should be detached for use as the buriel-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Pe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregna Other (specify			_	23d. Date of Month		y Day Yea	ar
rds, P	w requires thet been signed t should be delt	Ď	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause	e given in Part I.	23e.		~		cause of deal	
al Records,		Completed	05 W.					24a.	Was an autopsy performed? Kes 2□N	prio	r to com th?	sy findings ava pletion of caus D No	ailable se of
Division of Vital	or Attending Physiter death. Director: Atter this in by the funeral dir	Certification: To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)  3/27   Day 28e. Place of Injury At building, etc. (Spec	28b. Time of Injury 14 home, farm, stre	<b>A</b> M 28c. I	Other: 4 Nur Injury at Work? 1 Yes 2 N	SVB1 WAT 28f. Local City of	Residence cribe how injunction (Street a for Town, State	Iny occurred AS DR DED W Ind Number of	NY EA NTH or Rural	Scene 2 OF CA A STOPPE ROUTE Number 2 NO LE	AIR ED CAR
	To the Hospitei within 24 hours a To the Funerei I completely filled	edicai C	29a. Certifier 1☐ Certifying Phys (Check only one)	ician: To the best of my kner. On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the	ne time, date and my opinion, deatl	l place, and due to	o the cause(s	s) and manne	ar ae eta	had	עיו
	To the Youthin 2 To the Complete	W	29b. Signature and title of certifier	^			cense number			n, 27,			
	7		30. Name and address of person who con	O , MD			Penn Str	reet Bal	Ltimor	e, Mar	ylar	nd 2120	)1
	Sta Registr		31. Date filed (Month, Day, Year)  MAD 3 0 2006	32. Registrar's Sign	Angele .	Ĩ							

			for State Registrar	State of Maryland		irtment of He <i>tificate of E</i>		ental Hygle Reg.	0 0 0 0	00787
	-y	4	Decedent's Name (First, Middle, Last	t)				2. Date of Death		3. Time of Death
	Physici /Medio	_		s Marie Gree	enwoo		(8	March 29	Day Year  , 2006  4c. County of Death	2:30 A <sup>M</sup>
)	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or				
			4304 Quigley Pla 5. Social Security Number 6. Se		t birthday)	Temple If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince G	place (State or Foreign
	Funeral Director			□M 21XF 80		Months Days	Hours Min.	MAR 11.	ar) Cou	hington, DC
Ć.	P _		Usual Residence of Decedent	140.00						
	show	_	10a. State 10b. County		Town or Lo		-			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he M	Director	Maryland Prince  10e. Street and Number	George's	<u>_</u>	emple Hil	LS	100	Citizen of What Cou	
	with be or					207	/. O	109.		
	ha 23	Funeral	4304 Quigley Pla	12 Was Decedent Ever in U.S.	13. \	Vas Decedent of His f Yes, specify Cubar		ecify Yes or No-	USA 14. Race - Amer	
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or itema 23e or 28e-f show or other traumatic event, the Madical Examinatr such bundliked at	þ	1 ☐ Never Married 2 ☐ Married 3 [X]Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			Specify:	Rican, etc.)	Specify: White	, etc. ite
Maryland 21215-0036	2 hou	Completed	15. Decedent's Ed		16a. Deced	lent's Usual Occupa	tion	166	. Kind of Business/I	
2	e. And	nple	(Specify only highest grad	College (1-4or 5+)	life. L	kind of work done di OO NOT use retired)		ng		
2	filed wi Hygien other th	Con	12			Homemake		(Fire Adidate Ade)	Own Home	<u> </u>
u	be fill	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Mai		
<u> </u>	should ind Men ind marke umatic	Ç	Clifton C. Scros		10h Mailin	n Address (Street a		a M. Ogle	ety or Town, State, Z	in Code)
Z Z	d 2 si th an th an traur		Kathleen M. Scelzo			-			gtown, MD	
é,	1 an Heal tam 2		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name of		ate 200	Location - City or 1	Town, State
<u></u>	ages ant of it: if i		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemoval from State		matory or other place	0.40	9/06	Baltimore	, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ances.		21. Signature of Funeral Service Licen		22	Name and Address	of Facility			20
ä	Departing Import		Edward A. Gres	forchik	C 2	remation 99 Freder	Society o ick Road	of MD, Inc Baltimore	E; MD 2122	2.8
			Edward A. Gres  23a. Part1. Enter the disease, or compshock, or heart failure. List only of	one cause on each line.	Do not ent	er the mode of dying	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Cerebron	ascu	lan A	cciden	<i>t</i>		Onset and Death
ľ	/Medical Examiner		resulting in death)	a. Cere hrove  Due to (or as a conseque  b. Glaeralize	nce of):	1.11				S
	LAdminer	L	Sequentially list conditions,	b. Colorals 30	= d	Athero.	octenosi	>		Jean)
	bed nsit	ine	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		,					
	tra		Cause (Diseese or injury	moures	MIX	litras				10 nears
	a - la	Exan	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	litus				10 gears
760,	te be exe ysician a se burial-	cai Examiner	that initiated events	c. Due to (or as a conseque	nce of):	litus				10 years 35 years
68760,	rtificate be executed ng physician and as the burial-transit	dicai	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	litus				5 years 10 years 35 years
9	ath certificate be exe ttending physician a or use as the burial-	dicai	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d. Due to (or as a conseque  d. 23c. If yes, outcome of pregnanc  1 Live birth 2 Fetal d	cy leath 3	Ectopic pregnancy			23d. Date of deli	very
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			For State Registrar	State of Maryla		artment of F			giene Reg.No.006	09788
	Physici /Medio		1. Decedent's Name (First, Middle, La	Franci	5	GVAId		2. Date of Dea Month MA	Day 25 20	3. Time of Death 2251 M
	Examir Funeral	er		Sex 7. Age (In y)	rs. last birthday)	If Under 1 Year	r Location of Death  Mbl 4  If Under 24 Hrs.	8. Date of Birth	4c. County of I	Birthplace (State or Foreign
	Director		102-18-7424  Usual Residence of Decedent  10a. State 10b. County		81 Yrs.  City, Town or Lo	Months Days	Hours Min.	(Month, Day Aug 15	, 1924 N	Country)  EW York  10d. Inside City Limits
	the Maryli 28a-f sho	Director	Maryland Howar		-	Columbia			10g. Citizen of Wha	1 ☐ Yes 2 🔀 No
	23a or	ral Di	5400 Vantage P	oint Road Apt	#1106	2104	4		U.S.	*
980	be filed within 72 hours after death with the Maryland ital Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Exam her must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ⊒Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - , Black, \ Specify:	American Indian, White, etc. White
21215-0036	I within 72 h	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired Lness Own	during most of word)	king	16b. Kind of Busin	ess/Industry
Maryland 2	2 should be filed and Mental Hygie Is marked other surmatic event, It	To Be C	17. Father's Name (First, Middle, Las William E. Gir	ard					Maiden Sumame)	are a novies
	nd 2 sh lth and 27 is m traum		19a. Informant's Name/Relationship Catherine Girard 20a. Method of Disposition	(Wife)	5400	Vantage	Point Roa			, MD 21044
Baltimore,	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service ☐ Color	ty) Me	etro Cre		3-29	9-2006	20c. Location - City Catonsvi	11e, Maryland
Ba	permit. Departn Importe any inju		23a. Part1. Enter the disease, or con	Tukmam		Name and Address Witzke Fu 5555 Twir er the mode of dyin	ineral Ho Knolls		Iumbia, N	Maryland 21045
	Pnysician /Medical Examiner		shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	. Intracer	equence of):	Hype	Hersine	Heno	Muge	Interval Between Onset and Death
8760,	sate be executed obysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	equence of):					
O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	f delivery Day Year
ords, P	w requires thet been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.			te to the cause of death?  Probably 4 Unknown
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one)  1. Certifying Properties 2 Medical Example and title of certifier  29b. Signature and title of certifier	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death	r occurred at the tin vestigation, in my o	pinion, death occu	rred at the time, d	ause(s) and manne late and place, and 29d. Date signed (M	due to the cause(s)
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	1241		Howa M	completed cause of death (It	sem 23a) (Type, 57∫	Cedy L	4 lolu	ubit.	nd 21	2006
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:00PM M 23, Laura Α. Guinn March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Flintwood Court Ft. Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 579-24-0333 80 March 13.1926 North Carolina Director Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, Ita Medical Examerer must be notified at 1 ☐ Yes 2 ☑ No Directo Prince George's Maryland Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9008 Flintwood Court 20744 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2√XNo If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Year or Dates: Completed Prince George's Co. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glover Jones Margaret C. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Guinn (Son) 531 West 45th St. Apt. 3D New York, New York 10036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 29. 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Lipe 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton , MD 20735 23.1 art1. Enter the disea of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list for differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown this certificete has been sir ral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 8 No funeral director 25. Was case referred to medical Be 26. Place of Death | Check only we examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ို 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 5 Residence 6 □Other (Specify) 3 DOA 27. Manger of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel I
completely filled Teartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the E 29b. Signature and title of centities 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9131 Piscataway Rd.#260 Clinton, Md. 20735 Rene Grace. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2006

	= '	For State Registrar	State of Marylan		artment of H <i>rtificate of I</i>		Mental H	ygiene Reg. No	411115	09790
		1. Decedent's Name (First, Middle, Las	t)				2. Date of D			3. Time of Death
Physicia		Paul Lawre	nce Garne	r			March	23.	y Year 2006	3:10am м
/Medic Examin		4a. Facility Name (If not institution, give		<u>.</u>	4b. City, Town, or	Location of Dea			County of Deat	h
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Funeral Director			D., -D-	77 Yrs.	Months Days	Hours Mir	. (Month, L	ay, Year)	020 11 -1	hplace (State or Foreign untry)
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fand ow		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
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the h	Director	MD Prince G	eorges 0	<u>xon Hi</u>				10- 00	*********	
72 hours effer death with the M "natural", or Items 23s or 28s-f	늅				10f. Zip Code			10g. Ci	izen of What Co	untry?
ath v	Funeral				20745			UŞ	A	
ep Le	rue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? ( In, Mexican, Pue	Specify Yes or Norto Rican, etc.)	lo-	<ol> <li>Race - Ame Black, White</li> </ol>	
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be lied within 72 hours effer death with the Maryland tall Hygiene. It whygiene do other than "natural", or items 23s or 28s-f show avent, the Medical Exeminar must be notified at	0	17. Father's Name (First, Middle, Last)					ame (First, Midd			
d by ked ked	To B	Wilbert Garner				Addie	Carter			
Shou mar mar	-	19a. Informant's Name/Relationship (7	vpe, Print)	19b. Mailin	ng Address (Street a			ber City o	or Town State 2	(in Code)
1 end 2 should Health and Mer em 27 is marke		Vermelle Garner	Wife		Oxon Hil			-		
Hear Than		20a. Method of Disposition							ocation - City or	
Pages nent of h ent: if its		1 Burial 2 Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other place	e) Marc	ch <sup>Date</sup> 24,			
Pa men ent: ury		4 □ Donation 5 □ Other (Specify	) Le	ee Crem		200	06		inton, M	
permit. Pages 1 end 2 should be filed within Department of Health and Mehall Hygiene. Importent: if item 27 is marked other than eny injury or other treumatic avent, the Means once.		21. Signature of Funeral Service Licen	600	22	. Name and Addres	s ol Facility Life	e Funer	al Ho	ome, Inc	Macaza
8288		Doris X. A.	mo0257	. 6	9633 OTG	Alexande	eria Fer	ry Ro	oad Clim	ton, MD2073
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death	. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
Physician /Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	VEORUS	N OF	COL	.ON		
It he death certificate by the ettending phys lached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy				23d. Date of deli Month	very Day Year
w requires the been signed I should be det	à	Part II. Other significant conditions of HYPERTENS		ulting in the ur	nderlying cause give	en in Part I.		tobacco		the cause of death?
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Memory County (Control of Control						, , , , , , , , , , , , , , , , , , , ,	Cei	tificate o	f Death			Reg. No.	6	19/91
Formula Control Contro			1. Decedent's Name (First, Midd	lle, Last)	01								Year	3. Time of Death
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Physician Middleal Examiner  Physician Middle	Page ent o ht: If	4			oval from S	state			•		3-31-06	Lansd	owne,	Md.
Physician Micolical Examiner  Physic	alti		21. Signature of Funeral Service	License	21		22	2. Name and Ad	dress of Facil	lity	Balt	imore,	Md.	21202
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25. Was case referred to medical examiner?  1   Second Part   Second Par	P.C	Phy	quel			11 t	4- ^				1 🗆	Yes 2□ No	3 □ Pro	bably 4 Unknow
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25. Was case referred to medical examiner?  10 yes only one of the property of	cord w require been si should I	leted	Cornaegal	ling	Dise	nse					24a. Was perfe	s an autopsy ormed?	av	ailable prior to empletion of cause
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The state of the s			25. Was case referred to medic	al					26. Plac	ce_of Dea	th (Check only	one)		
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	0 5 5 7		27. Manner of Death		28a. Date o	of Injury	28b. Time o							
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	on ding th. : Afte	텵			(MONTI	n, Day Year)	injury			∃No				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Oivisi or Atten effer dea Director I in by the	ertifica	3 ☐ Suicide 6 ☐ Coul	d not be mined	28e. Place buildir	of Injury - At hong, etc. (Specify	me, farm, st	reet, factory, offi	ice		28f. Location ( City or To	(Street and Num wn, State)	ber or Rur	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DALSHAW: SALUIN (600 W. MOUNT Proclem 2 12 17)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hospitel 24 hours Funeral tely filled		(Check only 2 Medica	ing Physici al Examiner	: On the ba	asis of examinat	vledge, deat ion and/or ir	h occurred at the	e time, date a ny opinion, de	and place,	, and due to the rred at the time,	cause(s) and m	nanner as s , and due t	stated. o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DASHAN SALUIN (600 W MOUNT Find Ave Balta 2 12 17  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	thin 2	Me		ier	and mann	ioi sidibu.		29c. Lic	ense number	,		29d. Date sign	ed (Month,	Day, Year)
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State	2		30. Name and address of person	n who comp	SAL	e of death (Item	23a) (Type	Print) Mo	UNT G	2 ogc	LAN	Ball	02	1217
MAK 3 0 ZUUS Begge 18 Access			31. Date filed (Month, Day, Yea	r)	32. R	1		1		7				
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DHMH 17 Rev 1/2001

Registrar

		1	For <b>Amend</b> State Registrar	Items	2384250f2	Mandana	E/ <b>Per</b> a Cei	ME CE	98,40 of E	93/129 Death	yobd		giene	06	09793
M.	人 湖		1. Decedent's Name (Fi	rst, Middle, La	st)							2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Betty		Jean		He	ood				January			11:38A <sup>M</sup>
	Examin	er	4a. Facility Name (If not					4b. City, T			of Death			inty of Death	-
18			Anne Arund 5. Social Security Numb			ter . Age (In yrs. Ia	st hirthday)	Ann If Under 1	napo.	Lis If Under:	24 Hrs.	8. Date of Birt		e Arun	
466,	Funeral Director		216-36-834		I	67	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da June 27	, 1938	B WV	place (State or Foreign htry)
			Usual Residence of Dec	edent											
	arylan ehow	_		o. County	undo 1		Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director		nne Ar	mide r	ODen	LOII	104 71-4	0-1-				10a Citizan	of What Cou	
	72 hours after death with the Maryland Insturat', or Itema 23a or 28a-f ehow deat Exaciliter count be notilited at	2	10e. Street and Number					10f. Zip (	113				_		шу:
	eath	Funeral	453 Oakton	Road	12. Was Deced	ent Ever in U.S	i. 13. 1			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	U.S.	A . Race - Ameri	can Indian,
(0	r Iten	표	1 Never Married	2 Married	Armed Force	es? ! <b>T</b> YNo					i, Puerto	Rican, etc.)		Black, White,	
8	ral', o	1 by	3 XWidowed 4 □	Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes 2	TX NO	Specify:			Spe	ecify: W	nite
5-0	be filed within 72 hours ital Hygiene. Id other than "natural", event, the Madical Exp	Completed	15. (Specify o	Decedent's E	ducation a <i>d</i> e co <i>mpleted)</i>		(Give	dent's Usual kind of work	k doné d	uring most	t of worki	ing	16b. Kind o	f Business/In	dustry
121	within ene. then "	dm	Elementary/Secondar	y (0-12)	College (1-4	for 5+)		DO NOT use Bus Ai					Educa	ation	
7	filed within I Hygiene. other than	e Co	17. Father's Name (Firs	t, Middle, Last	)		•	DUS AI		18. Mothe	or's Name	(First, Middle,			
an	id be ental ked o	To Be	Howard Le	e Sigl	ev					Jе	ssie	Hartma	ın		
Maryland 21215-0036	2 should be and Mental is marked of sumatic eve	-	19a. Informant's Name				19b. Maili	ng Address	(Street a			I Route Numbe		wn, State, Zij	Code)
	P = 2 =		Mrs.Teres	a Lan	e /Daugh	ter	298 (	Oak Ma	nor	Driv		len Bur	nie, N	D 210	51
J.	0 0		20a. Method of Disposit		Removal from SI	CO	ace of Dispo metery, crei	matory or oti	her place			Date		on - City or T	
Ë	Pages ment of ant: If it ury or o		4 Donation 5			Nic Chu	hols   rch C	Bethel	_			5,2006			
Baltimore,	permit. Page Department of Important: if any injury or once.	d	21. Signature of Full P	Servine lice		nollad	1	Secon	d Addres	s of Facility	y Sin W GL	gleton en Burn	Funera	al Home 1. 210	e,P.A. 61
	*		23a. Part1. Enter the d shock, or heart fa	isease, or con ilure. List only	polications that can one cause on ea	used the death. ch line.	Do not ent	ter the mode	of dying	g, such as	cardiac o	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fina disease or condition	al	a Ac	luit	Kesp	what	m	12his	tree	55 5	emore	me	Criset and Death
	/Medical Examiner		resulting in death)	•	Due to (o	r as a consequ	ence of):		1			•	0		
	Š.	-	Sequentially list conditi	ons,	b. Due to (o	r as a consequ	ence of):								
h	ted nsit	nine	Cause, Enter Underlyin Cause (Disease or inju-	ng ⊀	200.0 (0										
<b>.</b>	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last		C. Due to (o	r as a consequ	ence of):					11/2	,		
760,	ysicia ysicia	cai		•	d				<u>-</u>		(	TON APPROVED	BY MEDICAL	EXAMINER	
99	ng ph as th	Ned	IC CEMALE:							C	ERTIFICA	TION APPROVE			
Вох	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE:  23b. Was decedent pre in the past 12 moi 1 □ Yes 2 ☑ No	nth <del>s</del> ?		ome of pregnar th 2 ☐ Fetal nt at time of de	death 3[	⊒Ectopic pre					23d.	Date of delive Month	ery Day Year
P.O.	that the de led by the a detached t	hysi	9 ☐ Unknown		9□ Unknov	WI						_			
	res tha	by P	Part II. Other significan	nt conditions	contributing to dea	ath but not resu	Iting in the u	inderlying ca	ause give	en in Part I		1			the cause of death?
ord	w require been sh should t	ted	_ Kece	trig	ht lie	ten 1	sob K	my des	5 6	engl	ull	119	Yes 2□N	o 3∐Pro	bably 4 □Unknown
Records,	e law r has be ge 2 sh	Completed	byh	emati	nec.	Sleed	and	e h	100	volen	mi	24a. Was autor	an 24	4b. Were aut prior to co death?	opsy findings available empletion of cause of
H		Cor	Cr	rest	due to g	raft di	srupt	ion					2 No	1 Yes	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred examiner?	to medical	Hospital:	-51			Othe	20		h (Check only o		1011 (0	4.
of		1. To	Yes 2 10 10 27. Manher of Death	-	28a. Date of	patient 2 🗍 8 Injury	28b Time o	of 2	8c. Injury Work	4 🗀 190		me 5 Resi			ry)
lon	Attending Indeed of death.  Sector: After by the funer	ation	1 Natural 5	Pending investigate	1 1		Injury Inknow	u.		<7 Yes <b>2</b> K⊡	No	Fall			
Division	Attendi er death. ector: A by the fu	Certification;		Could not l	28e. Place of	of Injury - At hor g. etc. (Specify	me, farm, st	reet, factory	, office			City or To	wn. State)		al Route Number,
Ö	tal or rs afte at Dii	Cer			HOSDI	tal					1	nne Arı	ındel 1	Medica	l Ctr. <del>mnapolis</del> MD
	Hospi 4 hou Funer ely fill	icai	(Check entry 2	Certifying P Medical Exa	miner: On the bas	sis of examinat	wledge, deat ion and/or in	th occurred anvestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	manner as ice, and due	mapolis,MD stated. to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and Mile	of certifier	and mann	er stated.		29c	. License	number			29d. Date si	igned (Month	, Day, Year)
<b>\</b>	5 7 × 7		1		1.1	10 - 1			Δ		200			1 1	
	$\circ$		30. Name and address	of person who	completed cause	of death (Item	23a) (Type			562			1	1001	MO 2,401
	10		Read	k Den	les mo	200	2 ma	drical	PL	ewy	Sun'	tszo	Anne	polis	MO 2,401
	Sta	ate	31. Date filed (Month,			gistrar's Signat		190	-		-			,	
	Regist	rar	J	ANZ 5	2006	Salver .	1 1	sauce.	P			<del></del> -			

			For State	State	of Marylai	•	artment of rtificate of		d Mental Hy	2006	09791
			Registrer  1. Decedent's Name (First, Middle)	Last)			imouto or	Douin	2. Date of D		3. Time of Death
п	Physici		David	Isenberg	Sr				Month	26, 2006	8:15 P M
)	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of De		4c. County of D	eath
			Clinton Conva	lescent	Center		Clintor	1		Prince	George's
	Funeral			6. Sex		. last birthday)	If Under 1 Year Months Days		Irs. 8. Date of B	irth 9	Birthplace (State or Foreign Country)
ш	Director		577-38-0569	1√2 M 2□ F	76	Yrs.			0ct. 1	лау, Year) 15,1929 Ма	ryländ
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ō	Virginia Staffo	rd		Frada	rickshur				1 ☐ Yes 2 No
	the 128	Director	10e. Street and Number	LU		rrede	ricksbur	8		10g. Citizen of What	Country?
	3a or	<u> </u>	110 Hudson Road	1			22405			U.S.	Α.
	death	Funeral	11. Marital Status	12. Was De	cedent Ever in l	J.S. 13.		Hispanic Origin?	(Specify Yes or Nuerto Rican, etc.)		merican Indian,
٥	or ite	Ē	1 Never Married 2 Marrie	Armed I	2 No 10	946-	iryes, specify Cui 1 □ Yes 2 <b>/</b> □ No		Jerto Hican, etc.)		•
21215-0036	be filed within 72 hours after death with the Maryland Artygiene. d other then "neturel", or items 23a or 28e-f ehow do other then "bedical Examinar must be notified at event, the Madical Examinar must be notified at	d by	3 ∰Widowed 4 Divorced	Year or	Dates: 10	949	TO 165 STING	эреспу.		Specify:	White
7	72 h	Completed	15. Decedent' (Specify only highes	s Education grade completed	1)	(Give	dent's Usual Occu kind of work done	during most of	working	16b. Kind of Busine	ss/Industry
2	in the state of th	m d	Elementary/Secondary (0-12)	Coltege	(1-4or 5+)		<i>00 not u</i> se <i>retiri</i> Truck Dr	,		Teamsters	Ilm i om
2	Hygie ther ther	ပ္	17. Father's Name (First, Middle, L	.ast)			IIUCK DI		Name (First, Middl	e, Maiden Sumame)	OHIOH
a	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other then "neturel", or items 23s or 28s-1 show aumatic event, the Modical Examinal must be notified at	To Be	Roy Isenberg					CI	leo Bett	is	
Maryland	should nd Men marka umatic	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Stree	t and Number or	Rural Route Num	ber, City or Town, Stat	e, Zip Code)
	and 2 eelth a n 27 le		Mark Isenberg	(Son)		110	Hudson R	oad Fred	dericksbu	rg, Virgin	ia 22405
			20a. Method of Disposition f** Burial 2 Cremation	2 Demousi from	1	Place of Dispo cemetery, crei	sition (Name of matory or other pla		clPate30,	20c. Location - City	or Town, State
Ĕ	Pag ment ent: h		4 Donation 5 Other (Sp		Re		tion Cem	-	2006	Clinton,	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny Injury or oti		21. Signature Furieral Service L	icensee						al Home, I	
	20 ± € a		G-1 Gan	m 146	1						ton, MD20735
			23a. Party. Enter the disease, or shock, or heart failure. List of	only one cause on	each line.	ith. Do not ent	er the mode of dy	ing, such as card	diac or respiratory	arrest.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a			piratel	y.	ailu	e	
	Examiner			Due to	O (or as a conse	quence of):	Co	acio			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conse	quence of):	26	0515			
	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	<b>1</b>							
Ď.	e exe	Ex	resulting in death) Last	Due to	o (or as a conse	quence of):					
8760	icate be executed physiclen and s the burial-transit	dlcal	3	d							
×	ding g	/Me	IF FEMALE:	23c. If yes, o	utcome of pregr	ancy				22d Date of	deliano
Box	leeth certifi ettending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 DLive	birth 2 Fet	al death 3	Ectopic pregnand Other (specify)	СУ		23d. Date of Month	Day Year
o.	res thet the de igned by the e be detached f	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk							
	s thet	by P	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
ğ	w require been sig should b	edt							_ 1□	Yes 2 No 3 □	Probably 4 DUnknown
Records,	m w M	Completed							24a. Wa		autopsy findings available to completion of cause of
r	9 c 6	ĕ							per 1 ☐ Yes	formed? death	
Vital	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?	-				26. Place of I	Death (Check only	one)	
<u> </u>	Physic this co	은	1 ☐ Yes 2 ☐ No			ER/Outpatier	I 3LI DUA			sidence 6 Other (S	Specify)
ב	ding Ph n. After th funeral	Ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Mc	ε of Injury with, Day Year)	28b. Time o Injury	W		28d. Describe	how injury occurred	
Division	Attending Physician: It deeth. •ctor: After this certific by the funeral director.	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	ce of Injury . At i	nome form et	M 1 [	]Yes 2 □No	28f Location	(Street and Number or	Pural Poute Number
<u>≥</u>	lor A after Direction by	Certification	4 ☐ Homicide determi	ned 200. Flat	ding, etc. (Spec	ify)	eet, factory, office			own, State)	Titla Tibule Namber,
	To the Hospital or Attendin within 24 hours after deeth. To the Funeral Director: Att completely filled in by the fun		29a. Certifier 1 💢 Certifying	Physicien: To the	he best of my kr	lowledge, deat	h occurred at the	ime, date and pl	ace, and due to the	e cause(s) and manner	as stated.
	n 24 I n 24 I he Fu	edical	(Check only 2 Medical E	xaminer: On the and ma	basis of examin inner stated.	ation and/or in	vestigation, in my	opinion, death o	ccurred at the time	, date and place, and	due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c. Licer	ise number		29d. Date signed (M	onth, Day, Year)
	11		Men	ma	MD		(	00990	1	3/28	100
	51		30. Name and address of person v	who completed ca	use of death (Ite	m 23a) (Type,	Print)	100 811	inston	DC	20010
	Sta	to.	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	)	W CONSTE	71011	1	20010
	Registr		MAD 3 O	2006		K An	and i				

ORIGINAL

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		1_ For State	State of Maryla				Mental Hyg	iene	0 00705
		T = State Registrar		Ce	rtificate of	Death	,	g. No. U	0 NA1AD
Physic		Decedent's Name (First, Middle, Last)	Helen		Jac	obs	2. Date of Deat Month MAR	Day	Year 0.06 02 <sup>50</sup> pM
/Medi Exami		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of	
Lxaiijii	ie.	Sunrise Assisted	Living		Со	lumbia		Howa	
Funeral Director		5. Social Security Number 6. Sex 1092-12-4335	7. Age (In yrs	s. last birthday) 4 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day Feb. 25	Year) .1922	9. Birthplace (State or Foreign Country)  New York
70		Usual Residence of Decedent  10a. State 10b. County	100.0	ib. Town and				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Maryia f shov	ō	Maryland Howard	100.0	Colu	imbia				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
r 28a-	by Funeral Director	10e. Street and Number		0010	10f. Zip Code		10	og. Citizen of Wh	nat Country?
23a c	alD	6500 Freetown Roa	d		2104	5		U.S.A	Α.
er des İtams	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
Maryland 21215-0036  d.z. should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 71s marked other than "natural", or Itams 23s or 28s-f show traumatic event, the Medical Exarti for must be rediffed at	by F	3 △ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
5-0	Completed	15. Decedent's Educ (Specify only highest grade	cation com <i>pleted)</i>	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	king	16b. Kind of Bus	iness/Industry
within than the Man	фшо	Elementary/Secondary (0-12)	College (1-4or 5+)	infe.	Bookk			New You	rk State
Hyginant, man,	Be C	17. Father's Name (First, Middle, Last)		1	DOOKK		e (First, Middle, M		
Yland 2' ould be filed v Mental Hygie varked other t	To B	Sam Solsky				Celi	a Rosenb	erg	
lary		19a. Informant's Name/Relationship (Typ				and Number or Rui			
e, N 1 and 1 ealth 1 ealth 1 ealth 1 ealth		Steve Jacobs (So			.0 Hall S	hop Road			nd 20759 Sty or Town, State
ages ant of h		1,  Burial 2  □ Cremation 3  □ R  '4 □ Donation 5  □ Other (Specify)	emoval from State	cemetery, cre-	matory or other pla rid Cemet	ce)			New York
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked any injury or other traumatic as once.		21. Signature of Funeral Service License				ess of Facility neral. Hou			
<b>©</b> && & & & & & & & & & & & & & & & & &		Muhrlo 14	(	~	DODO IMIL	KHOIIS K	oad Col	umbia, N	Taryland 21045
- de la companya de l		23a. Par 1. Enter the disease, or child shock, or heart failure. List only on	, ,		A selfen		or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		3 Den	rentia			3 years
Examiner		Spiritualistic list conditions		equence or).					1
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Iner	Securation of literature is a securation of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					
xecute and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
68760, clicate be executed a physician and as the burial-transit	calE			.,.					1
68 rtificat ng phy as th								7	
Box 68 leath certificate attending phy	lan/	tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	tal death 3	Ectopic pregnanc	N	/A	23d. Date Monti	
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify) _				
s that	by Pr	Part II. Other significant conditions con		- 4		en in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
Records, P.O. he law requires that the de s has been signed by the,	ted t	Type IL Di	abetes	mell	itus		1 □ Ye	s 2 No 3	Probably 4 Unknown
leco e a sh	Completed	typerten	sion, egg	etial			24a. Was ar autopsy	/ Dri	ere autopsy findings available or to completion of cause of
I VITAL REC ysician: The law is certificate has t director, page 2 s			on's dis	ease				No 1L	ath? ☐Yes 2DNo
Vital rsician: 1 s certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	□ EB/Outpaties	ot 30 DOA Ott	OF	th <i>(Check only one</i> ome 5 $\square$ Reside		(Specific) Adjusted
of Physical Control of the Phy		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe ho	-	- UV119
SiOr sndin eath. or: Af	catlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Your)	Підату		Yes 2 □No			
Division of or Attending Phy after death. Director: After this in by the funeral d	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (Str City or Town	eet and Number State)	or Rural Route Number,
spital nours naral y filled		29a. Certifier 1 X Certifying Phys	icien: To the best of my ki	nowledge, deat	h occurred at the ti	me, date and place,	and due to the ca	use(s) and manr	ner as stated.
Division of Vita Vita to the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)	ner: On the basis of examination and manner stated.	nation and/or in					
To To Con	2	29b. Signature and title of certifier	1~ m	. 0	29c. Licens		3		(Month, Day, Year)
/		30. Name and address of person who co	moleted cause of death (the	am 23a) (Tuna	Print\	5653	•	VIAICI	1 20, 2006
5		Harry Li, M	1.D. 10780	Hick	ory Ridg	erd,	Colum	bia, Y	nD21044
St. Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 0 200	Registrar's Sign	rature 6	de				

NLM 06-01669 Calvin Jones

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lvin Jo	nes	For	State of Ma		id / De	•	t of H	ealth a		-		Legible.	
C-120 1		1 - State Registrar				Certificate	e of L	Death			Reg. No.	1116	09796
Physic	oion	Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of Death
/Med		Calvin				Jor	nes			March	8, 2	2006	7:50 A M
Exam		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location o	f Death		4c.	County of Death	
		Maryland General	Hospital					more				NA	
Funera	1	·	i. Sex 7. Ag 1. ★ 2 F		last birth	Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da 2-15	h y, <i>Year</i> )	9. Birth Cou	place (State or Foreign
Directo	r	228-24-8561		79	Yr	S.				2-15	)-27		Va.
Pu ≱_		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	V. Town	or Location							10d. Inside City Limits
faryli	5	Md.	NA			ltimore							1 XYes 2 No
he h	Director	10e. Street and Number	·			10f. Zip	0-1-				10- 01	zen of What Cou	
with	ត់		Charach				2121	7			rog. Citiz	USA	intry ?
seth	by Funerai	2437 Francis	12. Was Decedent	Ever in 11	c				-:-2 (6	afi Van ar Na		4. Race - Amer	iona Indian
lter d	Ë	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces?		.3.	13. Was Deced If Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, White	
rs af	by F	3 □ Widowed 4 □ Divorced	d 1 □ Yes 2 √ I If Yes, Give X Year or Dates:	•		1 ☐ Yes 2	No.	Specify:				Specify: B]	ack
illed within 72 hours after deeth with the Maryland Hygiene. Hygiene "natural", or Items 23a or 28a-f ahow int, tre Madical Examiner must be notified at		15. Decedent's			16a. D	ecedent's Usua	I Occupa	ation			16b. Kir	nd of Business/li	ndustry
n 72	Completed	(Specify only highest	grade completed)		((	Give kind of wor fe. DO NOT us	k done d e retired	turing most	of worki	ng	100171		
the end	E O	Elementary/Secondary (0-12) Unkn	College (1-4or 5	)+)		Labo					Cor	structi	on
T Hyg		17. Father's Name (First, Middle, La	est)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
id be ental ked o	To Be	Jimmy	G.		Jon	es		V	erli	.a		Harris	3
a y latin 6 16.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. N	Mailing Address	(Street a	and Numbe	r or Rura	l Route Numbe	er, City or	Town, State, Z	ip Code)
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow an injury or other traumatic avant, the Marical Examinal must be notified at another.		Carla Stanley	Frier	nđ	3	904 W.	Cold	lsprir	ng La	ne , Ba	altin	nore, Mo	1. 21215
T He a st		20a. Method of Disposition		_		isposition (Nan crematory or o				ate		cation - City or T	
Pages 1 Bent of He nt: If its		1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				Mem. Pa		Θ) :	3-27	7-06	Rar	ndallsto	wn, Md.
Definitions, in permit. Pages 1 and 3 Department of Heelth important: if itsm 27 any injury or other trepones.		21. Signature of Funeral Service Lie	• •		-119	22. Name an		s of Facilit				ore, Md.	
Deparimpo		l lo l	o Wane			March						North Av	
		23a. Part1. Enter the disease, or co	omplications that caused	the deat	h. Do no	enter the mod	e of dyin	g, such as	cardiac c	r respiratory ai	rest.		Approximate
		shock, or heart failure. List or Immediate Cause (Final	Atherosc	ne.									Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	Due to (or as			Cardiov	003(	was	Ui	seuse	•		
Examine			Due to for as	a conseq	uerice or)	i							
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseq	uence of)	:							
Insit	Examiner	cause. Enter Underlying Cause (Disease or injury											
be executed icien and burial-transit	xa	resulting in death) Last	Due to (or as	a conseq	uence of)	:							
w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	call	(											
ficate p phy s the			U										
centi nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_					2	3d. Date of deliv	/erv
atte att	cia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			3 ☐Ectopic pro						Month	Day Year
the of	İsk	9 Unknown	9□ Unknown										
that that		Part II. Other significant condition	s contributing to death b	ut not res	ulting in th	ne underlying c	ause give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
uld be	d by									101	res 2	No 3□Pro	bably 4 Unknown
shou	Completed									24a. Was	an	24h. Were aut	opsy findings available
he lay	Ę									autor		prior to c death?	ompletion of cause of
n: T ficati or, pa	ပိ	25. Was case referred to medical							1.5	1 Yes	<del>-/\</del>	1 ☐ Yes	2□ No
ding Physician: The June After this certificate h	0	examiner?  1 Tryes 2 No	Hospital:	-1 0 1	TD/0.1-		Othe	20		(Check only o			
F File	5	27. Manner of Death	1 ☐ Inpatie		28b. Tin	atient 3 DO	^	4 🗆 140		ne 5 ∐ Hesio 28d. Describe I		Other (Spec	ity)
Afte Ping	tion	1 X Natural 5 ☐ Pending	(Month, Da	y Year)	Inju	iry M	8c. Injury Work	(? Yes 2∐t				, 000000	
death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	t be One Bloom of Ini	urv - At he	ome. farm					28f. Location /	Street and	Number or Ru	ral Route Number.
after Dira	Certification:	4 Homicide determin	building, et	c. (Specif	y)	,	, 000			City or Tov			
To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my kno	wledge.	death occurred	at the tur	ne, date an	d place. a	and due to the	cause(s)	and manner as	stated
24 h 24 h Fur etely	Medical	(Check only 2 Medical E)	caminer: On the basis of	examina	tion and/	or investigation,	in my of	pinion, deal	th occurr	ed at the time,	date and	place, and due	to the cause(s)
o this of the complete of the	₹	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (Month	, Day, Year)
⊢ <i>s</i> ⊢ ō		I him hi	mes				0	C 34	T.			Manala C	2006
Λ		30. Name and address of person w	<u> </u>	eath (lta-	n 22a) /T.	(ne Print)	U	.C.M.	Ľ.			March 8,	, 2006
$\mathcal{L}$		LING LI	w. i	outii (II⊕∏	23d/ (1)		P=	nn St	reet	Baltim	ore	Marvla	nd 21201
S	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature			ш. ОС.	LUCL	37411	,		
	trar	MAR 3 0	2000		Le .	balls	)						

ORIGINAL

			1 - For State Registrar	State of Ma	arylar	-	artmen rtificat			and M		giene Reg. No.	006	09797
	Physici	an	1. Decedent's Name (First, Middle, Last,						_		2. Date of Dea	th Day	Year	3. Time of Death
	/Media		Joseph				Jackso				March	25	2006	0644 AM
	Examir	er	4a. Facility Name (If not institution, give Union Memorial F				4b. City,		Location of			4c. Co	ounty of Death	
	Funeral		Social Security Number 6. S		e (In yrs.	last birthday)	If Under		If Under		8. Date of Birth	h		place (State or Foreign
L	Director		250-26-8768 <sup>15</sup>	M 2□F	82		Months	Days	Hours	Min.	(Month, Da) 3-12-	, Year)	Coul	S.C.
	D .		Usual Residence of Decedent  10a, State 10b, County		100 0	ty, Town or Lo								
	Aaryla r aho	5	Md. NA		100.01									10d. Inside City Limits  Yang 2 □ No
	28a-	Director	10e. Street and Number			Balti	10f. Zip	Code				10a. Citize	n of What Cou	ntry?
	h with		1819 E. 31st S	Street				21218	3			•	USA	,
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f ahow other traumatic event, the Medical Exeminer must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:		+	Was Deced If Yes, spec	**	ispanic Ori in, Mexicar Specify:		cify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:	
ş	2 hou	ted t	15. Decedent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ation	160		16b. Kind	of Business/In	dustry
212	e. e. n. Med.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or!	5+)	(Give	kind of woi DO NOT us	rk done d se retired	du <i>ring</i> mos )	t of workit	ng			,
Maryland 21215-0036	filed wii Hygien other th	Con	7th grade			Load	ler						nlehem	Steel
and S	2 should be filed and Mental Hygi is marked other aumatic event,	Be	17. Father's Name (First, Middle, Last)  William He	10.107.7	_	T1					(First, Middle,	Maiden Su		
2	should be and Mental s marked o umatic eve	၉	19a. Informant's Name/Relationship (Ty	enry	U	Jackson		(Street :		Rosa	l Route Numbe	r City or T	Jackso	
2	and 2 seath ar n 27 is		Mary Jackson	Wife							Baltin			1218
Je,	of Health of Health fitsm 27 I		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	1		ate		tion - City or To	
Ĕ	Pages ment of ant: If it ury or o		1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State		arrison				Cem.4	1-4-06	Owin	ngs Mil	ls, Md.
Baltimore,	permit. Pages 1 an Department of Heal Important: If itsm 2 any injury or other ance.		21. Signature of Funeral Service Licens	_		22	2. Name an	d Addres	s of Facilit	ty	Baltim	nore,	Md. 2	1202
	0 0 7 ≈ 0		Dlady	Wan			March					***	cth Ave	
j	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	ne.		er the mod	e or ayını	g, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a conseq	juence or).								
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	quence of):								
	cate be executed physician and the burial-transit	Examiner		:										
8760,	be ex ician burial	ai E		Due to (or as	a conseq	(uence or):								
287	ficate physis the	edicai		j										
O. Box	The law requires that the death certific Ne has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	al death 3[	]Ectopic pr ] Other <i>(sp</i>		·			230	d. Date of delive Month	ery Day Year
٦.	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions con	ntributing to death b	ut not res	sulting in the u	nderlying c	ause give	en in Part I		23e. Did to	bacco use	contribute to the	he cause of death?
g	quire; an sign ruld be	ed by									1 🗆 Y	es 2 1	No 3□Prot	pably 4 □Unknown
ပ္မ	e law re has beo ge 2 sho	Completed									24a. Was a		24b. Were auto	psy findings available mpletion of cause of
<u> </u>		Con									perfor		death?	2□ No
VII a	Physician: The la rthis certificete has rai director, page 2	Be	25. Was case referred to medical examiner?	lospital:				Otho	55		(Check only or			
5	Physical direction	. To	1 Yes 2 No	1 ☐ Inpatie		ER/Outpatier 28b. Time of			4 🗆 Nu		ne 5 Resid			( <del>ک</del> )
0	nding th: :: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ý Year)	Injury	м	8c. Injury Work 1 🔲 `	<br Yes 2 □			,,		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funers! Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At h	ome, farm, str fy)	eet, factory	, office	,	2	28f. Location (S City or Tow		Vumber or Rura	al Route Number,
	pital c urs af prst D	Cel	00- 0-47											
	Hos 24 ho Fun etely (	edical	29a. Certifier Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis o and manner st	t examina	ation and/or in	n occurred vestigation,	at the tim , in my op	ne, date an pinion, dea	d place, a th occurre	and due to the o ad at the time, o	ause(s) ar date and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To the Hospita within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certifier				290	. License	number			29d. Date s	signed (Month,	Day, Year)
			1/m	- M.D.				Doc	533	573		Morrel	n 25,	2006
	621		30. Name and address of person who co			n 23a) (Type,	Print) F	aul	Kai	Vg,				
	)		201 East Univer 31. Date filed (Month, Day, Year)		ay ,	Balti	more	MD	7 212	218				
	Sta <b>Re</b> gistr		MAR 3 0 2006	32. Hegistr	ar a signa	ature	0							

			1 - State Registrer Amend Item		Maryland /	_				nd Me			21116	ng-	7 Q A
			Decedent's Name (First, Middle, La	st)	Pny G85	4-4/	12700	) JH		2	. Date of Dea			3. Time of	Death
	Physici /Medic		Sharon O. Kokal								Month arch	28,	2006 Year	11:50	a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give	e street and numb	oer)		4b. City, 1	Town, or	Location of	Death		4c.	County of Death		
			144 Drexel Drive  5. Social Security Number 6. S	Sex 7	Age (In yrs. last t	nirthday)	Seve If Under		Park If Under 2	4 Hrs.   g	. Date of Birth		nne Arur		4 Familia
	Funeral Director		-	1□ M 25€F	60	Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	Cou	place (State o	_
			Usual Residence of Decedent								ept. 12		945 New	Jersey	7
	show	-	10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside Ci	•
	he M	Director	Maryland Anne Aru	ındel	Sever	na P	T					-	}	1 🗌 Yes	Z X NO
	with the cort		10e. Street and Number				10f. Zip					10g. Citi	izen of What Cou	ntry?	
	ns 23	era	144 Drexel Drive	12. Was Deced	ent Ever in U.S.	13. \		146	spanic Origi	in? (Specif	v Yes or No-		ISA 14. Race - Ameri	can Indian	
9	within 72 hours after death with the Maryland ene. then "neturet, or Items 23e or 28e-f show he Medical Exerties maal be rodithed at	Funeral	1 Never Married 2 Married	Armed Forc	es?					Puerto Rio	y Yes or No- can, etc.)		Black, White		
03	ours :	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		I□Yes 2	ZIZI No	Specify:				Specify: Wi	nite	
21215-0036	be filed within 72 hours ital Hygiene. d other then "neturel", event, the Medical Exe	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	(Give	lent's Usua kind of wor	k done a	unina most	of working		16b. Ki	ind of Business/Ir	ndustry	
12	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4	1		OO NOT us	e retirea,							
	iled Hygi Ithar nt.		17. Father's Name (First, Middle, Last	4	<u> </u>	omem	aker		18. Mother	's Name (F	First, Middle,		n Home		
Maryland		To Be	John Joseph O'Mea	ra					Donna						
ary	d 2 should th and Mer 7 is marke treumetic		19a. Informant's Name/Relationship (		19	b. Mailir	g Address					r, City o	r Town, State, Zij	o Code)	
	C = 0 L		David Kokalis- hu	ısband	1.	44 D	rexel	Dri	ve, S	evern	a Park	, M	D 21146		
Baltimore,	of the		20a. Method of Disposition  **ED Burial 2 Cremation 3 C	Removal from St	20b. Place cemet	of Dispo	sition (Nam natory or ot	ne of ther place	9)	Date	9	20c. Lo	cation - City or T	own, State	
Ë	Pag nent: ant:		* 4 ☐ Donation 5 ☐ Other (Specif	<i>(y)</i>	Meador	wrid	ge Me	moria	l Park	4/1/	2006 E	Elkr	idge, MI	)	
Baj	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer	nsee		22 G	. Name and ary L	d Addres . Ka	s of Facility ufman	Fune	eral Ho	me.	at MMP,	TNC	
	40144		23a. Part1. Enter the disease, or com	unlications that cau	sad the death. De	$-\bot 7$	250 W	ashi	ngton	Blvd	l., Elk	rid	ge, MD 2	1075	
	200		shock, or heart failure. List only	one cause on eac	th line.	0.0	0.11			ardiac or n	espiratory arr	est,		202 MODES Onset and L	AS eath
	Pnysician /Medical		disease or condition resulting in death)	a	dastoma		UNIO	me						13 mon	<del>41</del> 15
	Examiner			D09 (0)	as a consequenc	e Oi).									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	e of):									
$\sqrt{}$	scutec ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C											
8760,	icate be executed physician and s the burial-transit	E	resorting in death) Last	Due to (or	as a consequence	e of):									
387	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		_ d											
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy								23d. Date of deliv	90/	
m.	death e atter	iciai	in the past 12 months?	4 Pregnar	h 2 Fetal dea It at time of death		Ectopic pre Other (spe	egnancy ecify)					Month	- ,	'ear
0	at the de by the a tached	hys	9 Unknown	9□ Unknow	'n										
S,	es tha igned be del	by P	Part II. Other significant conditions of	contributing to dea	th but not resulting	in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute to t	he cause of d	eath?
Records,	w requir been si should	ted									1 🗆 Y	es 2[	IMo 3□Prol	bably 4 □U	Inknown
ec	las be	Completed									24a. Was a autops	SY	24b. Were auto	opsy findings a	available ause of
<u>=</u>		S									perform 1 Tes	med?	death? 1 ☐ Yes		
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death (C	Check only on	10)			
of	Phys r this ral di	To.	1 ☐ Yes 2 ☑ No  27. Manner of Death	. 1 🗆 Inp	atient 2 ER/C	outpation Time of			4   14015		5 Reside		Other (Special	fy)	
Division	Attending I r death. ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Day Year)	Injury	м	Bc. Injury Work 1 □ Y	? ′es 2 □ N		2. 20001120 11	ow injur	y occurred		
Visi	il or Attendii after death. Director: A J in by the fu	ifica	3 Suicide 6 Could not b	e 28e. Place o	Injury - At home,	farm, stre	eet, factory,	, office		28f			d Number or Run	al Route Numl	ber,
ā	tel or A rs after el Direc ed in b)	Certification:	4 - Homeda	building	, etc. (Specify)						City or Town	n, State	)		
	To the Hospitel or within 24 hours after to the Funerel Director completely filled in the formulation of the	Medicai	29a. Certifier 1 Certifying Pt (Check only one) 1 Medicel Example	nysician: To the b miner: On the bas and manne	is of examination a	ge, death and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, death	place, and occurred	due to the cat the time, d	ause(s) ate and	and manner as s place, and due t	stated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1				License					e signed (Month,		
)			Muslus Bla	ilulur	MO		AT	414	7357.	- 170	89	Mar	h 29,	2006	
	15		30. Name and address of person who	completed cause	MO of death (Item 23a )HNS HCP	) (Type,	Print)		,	e 1-00	7	imi	RAITIA	NEM	ARYCAN
	Sta	te	JASHZI BLAKELE 31. Date filed (Month, Day, Year)	32. <b>3</b> 59	OHNS HCK	KINS	1550	OR	LEIGN.	> 5//	LEE 1)	וניין	ONCI/II	TORCE)	21231
	Registr		MAR 3 0 1	2006	istrar's Signature	A	and)								

Physicia	đ	State     Registrar  1. Decedent's Name (First, Middle)	a Last)	<u> </u>	Timeate of	Death	Reg 2. Date of Death	No.JUU	3. Time of Death
		Rose C.					Month		006 12:15 A <sup>M</sup>
/Medica	-	4a. Facility Name (If not institution			4b. City, Town, o	or Location of Death	riai Cii	4c. County of	
	) 注:	Greater Balti	more Medical	Center	Towson			Baltim	
uneral		5. Social Security Number	6. Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 10,	94A 04 0	9. Birthplace (State or Foreign
ctor		218-62-4774 Usual Residence of Decedent	10 W 29A1	87 Yrs.			June 10,	1918	Maryland
ם		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
nny injury or other traumatic event, <u>tra Mudical Expriser mest he notified at page.</u>	ctor	MD Ba	ltimore	Timon	Lum				1 ☐ Yes 2 💆 No
	by Funeral Director	10e. Street and Number 140 Greenmeado	w Drive		10f. Zip Code 21 093		10g	. Citizen of Wh	
	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-		American Indian,
	F	1 ☐ Never Married 2 ☐ Marr	Armed Forces? ied 1 ☐ Yes 2 ☑ No If Yes, Give	0	If Yes, specify Cub.  1 ☐ Yes 2√2 No	an, Mexican, Puerto l Specify:	Rican, etc.)		White, etc.
	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:				-	Specify:	White
	Completed	15. Deceden (Specify only highe		16a. Dece	edent's Usual Occup e kind of work done	oation during most of workii d)	ng 16	b. Kind of Busi	ness/Industry
	дшс	Elementary/Secondary (0-12)	Cotlege (1-4or 5+	-)	omemaker	0)		Օար Ի	nome
	Ö	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle, Ma	iden Surname)	
	To Be	Rosario	Papa			Rosa		Cimmic	)
1		19a. Informant's Name/Relations Thomas N. LaPe			-	and Number or Rura			tate, Zip Code)
1		20a. Method of Disposition			osition (Name of amatory or other place				ity or Town, State
1		1 Burial 2 Cremation 4 Donation 5 XOther (S	3 Removal from State	1		<sup>ce)</sup> 4/1/			River, MD
d	1	21. Signature of Funeral Service							Home, Inc.
a		MILLE	with the same of t			rd., Tows		21204	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to	the death. Do not en	iter the mode of dyir	ng, such as cardiac o	r respiratory arrest		Approximate Interval Between
ı		tmmediate Cause (Final disease or condition				Funknoi		nary	Onset and Death
I P		resulting in death)	Due to (or as a	consequence of):	430	001.101	~!\ !!!!	iaci y	
	_	Sequentially list conditions,	b. CHF						
-	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Bilater	consequence of):	ural e	Frusion			
	xar	that initiated events resulting in death) Last	U	consequence of):	mai e	1 14310	/ \		
	cai		La Atria	1 Fib	rilation	Λ			
		IS SELVALE							
1	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐Live birth 2		□Ectopic pregnancy	,		23d. Date	
	Physician/Med	in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	4☐ Pregnant at ti 9☐ Unknown	ime of death 5	Other (specify)	·		Month	n Day Year
	Ph	Part II. Other significant condition	ens contributing to death but	t not resulting in the	underlying cause giv	ren in Part I.	23e. Did tobac	co use contrib	ute to the cause of death?
	5		•	<b>,</b>	, , , , , , , , , , , , , , , , , , ,		1 ☐ Yes		☐ Probably 4 ☐Unknown
- 1	0						24a. Was an	24h Wa	ere autopsy findings available
	et						autopsy	pric	or to completion of cause of ath?
	omplet						performe		
	e Completed	25. Was case referred to mertica				26 Place of Death	1 □ Yes 2		Yes 2 No
	Be	25. Was case referred to medical examiner?	Hospital: 1	t 2 ☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Death	1 ☐ Yes 2 Check only one	No 1	Yes 2 No
	To Be	examiner? 1 Tes 2 No 27. Manner of Death	Hospital: 1 Inpatient	28b. Time (	III 3DDOA	ner: 4 🗆 Nursing Hor	1 □ Yes 2	No 1 ☐	Yes 2 □ No (Specify)
	To Be	examiner?  1  Yes 2  Yo  27. Manner of Death  1  Natural 5  Pendin 2  Accident investig	Hospital: 1 Inpatient 28a. Late of Injury (Month, Day	28b. Time (	of 28c. Injur	ner: 4 🗆 Nursing Hor	1 ☐ Yes 2 (Check only one) ne 5 ☐ Residence	No 1 ☐	Yes 2 □ No (Specify)
and the second s	To Be	examiner? 1 □ Yes 2 □ Vo  27. Manner of Death 1 □ Natural 5 □ Pendin	Hospital: 1 Inpatient 28a. Late of Injury (Month, Day)	Year) 28b. Time of Injury	of 28c. Injur Wor M 1	er: 4 Nursing Hor y at k? Yes 2 No	1 Yes 2 (Check only one) ne 5 Residence 28d. Describe how	te 6 Other injury occurred	Yes 2□ No (Specify)
	Certification: To Be	examiner?  1  Yes 2  to  27. Manner of Death  1  Natural 5  Pendin investic  2  Accident investic  3  Suicide 6  Could determ  29a. Certifier 1  Certifyir	Hospital: 1 Inpatient  28a. Late of Injury (Month, Day  28e. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)	of 28c. Injur Wor M 1	y at tries 2 No 2 Yes 2 No 2	1   Yes 2     Check only one     ne 5   Residence     Re	tee 6 Other injury occurred and Number State)	Yes 2 No (Specify)  or Rural Route Number,
	Certification: To Be	examiner?  1	Hospital: 1 Inpatient  28a. Late of Injury (Month, Day pation  28e. Place of Injur building, etc.  g Physicien: To the best of exeminer: On the basis of e and manner state	Year)  28b. Time of Injury  y - At home, farm, si (Specify)  my knowledge, dea examination and/or in	of 28c. Injury Moret, factory, office th occurred at the fire those stigation, in my contents.	And the state of t	1   Yes   2     Check only one     ne 5   Residence     Residence	te 6 Other injury occurred and Number State)	Yes 2 □ No  (Specify)  or Rural Route Number,  her as stated. d due to the cause(s)
	To Be	examiner?  1 Yes 2 to  27. Manner of Death  1 Natural 5 Pendin investic  3 Suicide 6 Could determ  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient 28a. Late of Injury (Month, Day 28e. Place of Injury building, etc.  g Physicien: To the best of exeminer: On the basis of e and manner state	Year) 28b. Time Injury  y - At home, farm, si (Specify)  my knowledge, dea examination and/or indeed.	of 28c. Injury Wor M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ner: 4 Nursing Hory at k? Yes 2 No  me, date and place, a spinion, death occurred to the number	1   Yes   2     Check only one     ne 5   Residence     Residence	te 6 Other injury occurred and Number state)  se(s) and mann and place, and the signed (	Yes 2□ No  (Specify)  or Rural Route Number,  mer as stated. d due to the cause(s)  Month, Day, Year)
	Certification: To Be	examiner?  1 Yes 2 to  27. Manner of Death  1 Natural 5 Pendin investic  3 Suicide 6 Could determ  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient  28a. Late of Injury (Month, Day pation not be 28e. Place of Injury building, etc.  g Physicien: To the best of exeminer: On the basis of e and manner state	Year)  28b. Time injury  y · At home, farm, si (Specify)  my knowledge, dea examination and/or independent	of 28c. Injury Wor M 1 1 28c. Injury Wor M 1 28c. Injury Wor M 1 28c. Injury Wor More More More More More More More Mo	Ner: 4 Nursing Hory at k? Yes 2 No  me, date and place, a spinion, death occurred to the number	1   Yes   2     Check only one     ne 5   Residence     Residence	te 6 Other injury occurred and Number State)	Yes 2 □ No  (Specify)  or Rural Route Number,  mer as stated. d due to the cause(s)  Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Stuart March 2006 Allan 9:00 P Morgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 643 Walnut Avenue North Beach Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F Min. 213-58-9350 Yrs. Director 53 10. Maine Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Anne Arundel North Beach 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 643 Walnut Avenue 238 20714 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify 3 ☐ Widowed 4 ☐ Divorced White "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Drywall Hanger Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Eugene Morgan Frances Tarbell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 in other tra Taryn M. Morgan/Wife 643 Walnut Avenue North Beach, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H important: If ite any injury or of 2058. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation → 5 ☐ Other (Specify) Metro Crematory, Inc. 3/30/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Encensee 299 Frederick Road Baltimore, MD 21228 Edward Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ear) /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physiclen and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGADDA 31. Date filed (Month, Day, Year) MAR 3 0 3 Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #18 Per FH G854 Cartilicate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death **Physician** -2006 /Medical Examiner , Town, or Location of Death me **Funeral** 9. Birthplace (St. Country) 120-07-8/08 Months Days Hours Min. 7 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. Cit Town or Location If item 27 is marked other than "neturel", or items 23s or 28e-f show or other treumstic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director mold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 21012 OX Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1□Yes 2X No Specify: Blac Specify þ 3 □ Widowed 4 □ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife, DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b Kind of Business/Industry Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame 1 and 2 should be Health and Mental Walker Frandeline 19b. Mailing Address r I Route Number, City or Town, State, Zip Code) 62 2/0/2 Baltimore, 20b. Place of Disposition (Namcometery, crematory or or of Disposition State permit. Pages 1 Department of H Location - City or Town. 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) eral Septice Licensee 21 Signature of Fu any e disease, or com, lications that caused the death. Do not enter the mo in failure. List only one cause on each line. Approximate Interval B. tween Onset and Death 23a. Part1. Immediate Cause (Final disease or condition resulting in death) **Physician** 4 0 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed tran and Due to (or as a consequence of): attending physician a for use as the burial Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 DFetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown 2 (2/No 1 ☐ Yes Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate Division of Vital 1 Yes 2 **7** No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Funeral Director: After th completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 A atural Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of centific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAR 3 32. Regerrar's Signature State 2006 Registrar

4000

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and N	Mental Hy	-	bie. 16. 09802
	Physici /Medi	cal	Decedent's Name (First, Middle, Last)     Barbara Ann Mitch      Ann Ann Mitch      Ann Mit	el1		th City Town	r Location of Death	2. Date of De Month MAR	Day	Year 3. Time of Death 5: 28 A M
	Examir	ner	Anne Arundel Medi	cal Center	In a A bringh alon V	Annapo	lis	To 5	Anne A	runde1
100	Funeral Director		5. Social Security Number 215-38-4014 6. Sep 1 C	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Nov 26		Birthplace (State or Foreign Country) CT
	Maryland -f show	tor	10a. State 10b. County MD Anne Arus		n Burn:					10d. Inside City Limits
	3a or 28e	Il Direc	10e. Street and Number 1612 Bedford Rd			10f. Zip Code 21061			10g. Citizen of V USA	
900	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28e-f show he Madical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blac Specify	e - American Indian, sk, White, etc. v: White
21215-0036	ed within 72 hogiene.  er then "natu.  the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired Homemaker	during most of work d)	aing	16b. Kind of Bu	usiness/Industry
Maryland	2 should be filed v n and Mental Hygie ie marked other t reumatic event, th	To Be (	17. Father's Name (First, Middle, Last) Albert Curtis Adam				18. Mother's Nam	e (First, Middle ice Keni		Θ)
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: if item 27 is marked other then "natural", or itema 23a or 28e-f show empty injury or other treumatic event, the Madical Examiner must be notified an once.		19a. Informant's Name/Relationship (Ty. Robert S. Mitchell 20a. Method of Disposition 1 \( \frac{\mathbb{M}}{2}\) Burial 2 \( \text{Cremation} \) 3 \( \text{R} \) 4 \( \text{Donation} \) 5 \( \text{Other} \) (Specify)	l Husband	1612 Place of Dispo		œ)	Burnie	, MD 21	061 City or Town, State
Baltir	permit. P Departme importan eny injur.		21. Signature of Funeral Service License	De l'e	22	. Name and Addre	ss of Facility	, P.A.		
760,	w requires that the death certificate be executed by Waland been signed by the ettending physicien and should be detached for use as the burial-transit	ilcal Examiner	23a. Part. Enter the disease, or combine shock or heart failure. List only or limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	YOCAR quence of); ART; quence of);	Britis mode of dyling	ig, štětvás čárdiác ENFAR C	or respiratory a	riest,	Z I Opproximate Interval Between Onset and Death
P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.  Re the Funerel Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year
ords, P	requires that been signed b hould be deta	eted by Pł	Part II. Other significant conditions cor	HEART F.	ALLUA	E	en in Part I.		Yes 2□No	
al Rec	i: The law icate has l		CIRRHOSIS					24a. Was auto perfo 1 Yes	rmed? c	Were autopsy findings available prior to completion of cause of death?  Yes 2 No
fVit	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient 2 🔀	ER/Outpatien	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			er (Specify)
Division of Vital Records,	To the Hospitel or Attending Physician: The law within 24 hours after death.  Re the Funerel Director: After this certificate has completely illed in by the funeral director, page 2	Certification:	27. Manner of Death 1 🛱 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Specif	28b. Time of Injury ome, farm, strey)	28c. Injun Worl	y at	28d. Describe	how injury occurr	
	Hospitet	Medical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of my knotes: On the basis of examina and manner stated.	owledge, death	n occurred at the tin	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To the within ? To the comple	Med	29b. Signature and title of certifier	and mariner stated.		29c. License				d (Month, Day, Year)
1	0		30. Name and address of person who co		n 23a) (Tvoe		7531	/	MAR 2	9,2006
į.	У						sville,	MD.	21108	
· · · · · · · · · · · · · · · · · · ·	Sta Registi	ite ar	Mohit Negi 860 31. Date filed (Month, Day, Year) MAR 3 0 20	06 Segistrar's Signa	G. A	arti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23atePtr Maryland / Department of Health and Mental Hygiene II,25 per ME,6853,03/...29/06dhb Reg.INO. 1 = For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 02:18AM Vemell Moulden Feb elestine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | It Under 24 Maryland Medical Center 5. Social Security Number 219-52-73 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New YORK yrs. last birthday **Funeral** 7587 Days Min 1 □ M 2 X F Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show or other traumatic avant, the Madical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ington the US 701 Itams 23a 211 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 📉 o Specify: Specify: lac permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", any highry or other traumatic avant, the Medical East once. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12-4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be =d ward ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) in Rd. Tetters 5652 atousville, 21228 ma, Drenda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Carmel 3-06 4 □ Donation 5 □ Other (Specify) em. ndalk 22. Name and Address of Facility Fred Hillon 21. Signatur Funeral Service License ass my P. march reneral Hone Bulto , md. 21229 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease of condition resulting in death) hellorrhage in brain Physician /Medical Due to (or as a consequence of Examiner embo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner as a consequence of detached for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed tha attending physician and Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAMINED IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate hes been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cocaine use, Hypertension, Chronic obstructive 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending efter death.

I Diractor: Al 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours e To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) istalle Feb. 07 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ristalle A. Cox Greene Baltimore, MD South street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2006 Registrar book

			1 - For State Registrar	State of Ma	ryland /		artment of H <i>tificate of L</i>			giene Reg. No.	106	09804
	Physici	an	1. Decedent's Name (First, Middle, Las			-			2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Norma  4a. Facility Name (If not institution, give	Marche	ndor	2			Manch	20	2006	1:00 AM
	Examir	er	16 0 6	-			4b. City, Town, or		1		ounty of Death	2
		Н.	5. Social Security Number 66. So	Genera /	(In yrs. last b		If Under 1 Year	- 616 If Under 24 Hrs.	8. Date of Birt			place (State or English
	Funeral Director			_M 2 € F	58	Yrs.	Months Days	Hours Min.	Sept.	y, Year)	47 II1i	place (State or Foreign htry) NOIS
	land ow		10a. State 10b. County		10c. City, Tox	wn or Lo	cation				1	Od. Inside City Limits
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	th wil	aiD	5701 Brothers Par	tnership C	ourt		21045	5		Į	J.S.A.	
350	within 72 hours after death with the Marylar ene. than "naturel", or iteme 23a or 28a-f show ha Madigal Examinar must be notilied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of His I Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, pecify: B1a	etc.
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and	<b>₽</b> ≅ ₽ ●	Be	17. Father's Na <i>me (First, Middle, Last)</i> Solomon Johnson						ne <i>(First, Middl</i> e, e Gatson	Maiden Su	mame)	
<b>S</b>	should nd Men merke umatic	٩	19a. Informant's Name/Relationship (7		10	h Mailin	g Address (Street a			or City or To	num State 7in	Code
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5	Physic this c	္	TE THE ZENO	Hospital:			3 DOA Othe	4   IABI SILIG L	ome 5□ Resid			y)
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<u>≥</u>	efter Dire d in by	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	aim, sue	et, raciory, onice		City or Tow		annos or rurs	i riodie ramber.
	ne Hospital or Attendin n 24 hours effer death. ne Funeral Director: Ali lietely filled in by the fur	Medical C	29a Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iner: On the basis of and manner stat	examination a	e, death nd/or inv	contined at the time estigation, in my op	e, date and place inion, death occu	and due to the t rred at the time, o	taues(e) and date and pla	d manner as el ace, and due to	ated the cause(s)
	To the Pwilnin 24	Me.	29b. Signature and title of certifier				29c. License	number		29d. Date s	igned (Month,	Day, Year)
			myz		ms	7	046	120		Marc	4 20.	Zuor
	10		30. Name and address of person who d	completed cause of de	ath (Item 23a)	(Type, I	Orine)		77		1 4-7	
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State of Maryland / Department of Health and Mental Hygiene 1 1 6

		•	For State Registrar	State of Maryland		rtificate of L			Reg. No.	10	03000
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea			3. Time of Death
	Physicia		Glenn Edward	Myles				Month March_2	Day 27. 2006	Year	5:05 P M
Š	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	TIGIT CIT 2	4c. Count		
	Examin		Clinton Conva	lescent Center		C	linton		Pr	ince	George's
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		219-74-4621	ДM 2□F	42 Yrs.	Months Days	Hours Min.	June 27	<b>1</b> 963	Was	hington DC
	g		Usual Residence of Decedent								
	how		10a. State 10b. County		, Town or Lo	ocation					10d. Inside City Limits
	B Ma	cto	Maryland Prince	George's	La	andover					1 □ Yes 2√√No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Co	untry?
	th w		8821 Sterling	g Street		2078	85		Uni	ted	States
	dea me	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Ame	rican Indian,
0	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or iteme 23e or 28e-f ehow ent, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2XXNo If Yes, Give		1 ☐ Yes 🏋 No	Specify:		Speci		Black
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ย์	Heal Heal em 2	1	20a. Method of Disposition			osition (Name of matory or other place			20c. Location		
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D D	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important; if item 27 is marked other then "naturel", or iteme 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner mast be notified at once.		1.1000	L M0015		lexandria					
			23a. Part1. Enter the disease, or com	plications that caused the death		ter the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
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7	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ience of):	Cana	NO ANICLES	W 11.2			1 7
	Examiner			Rome	PC	Cand Silve					3M.
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Ď	en ar		resulting in death) Last	Due to (or as a consequ	ience of):						
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_	ng ph	Ved	IF FEMALE:								
ŏ	death cert e ettendin d for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		□Ectopic pregnancy			1	ate of deli	ivery Day Year
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S	A C O A	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, iarm, st	reet, factory, office		City or To		iber or Mi	ural Route Number,
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	Funeral Director		5. Social Security Number 216-09-9200 6. S	IDM 2KIE	(In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 2-1	irth ay, Year) 7–10	9. Birthp Coun	lace (State or Foreign try) S.C.
	and W		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	reation					04 1-14-04-11-1-
	within 72 hours after death with the Maryland ane. then "naturel", or items 23s or 28e-f show the Medical Evaruiter trast by modified at	Funeral Director	Md. N			imore				10	0d. Inside City Limits  XXYes 2 □ No
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	ath w	rai	1101 N. Milton	Avenue		21213	3		USA		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importence of Health and Mental Hygiene. Importence if item 27 is marked other then "naturel", or items 23a or 28a-1 show any Injury or other treumatic event, it is Medical Ever it natice is indifficed and once.	To E	Peter  19a. Informant's Name/Relationship (		Eckles	og Address (Stroot	Janni and Number or Rura			lggir	
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Baltimore,	ages 1 ant of H nt: If iten y or oth		20a. Method of Disposition  1  → Burial 2  → Cremation 3  →  4  → Conation 5  → Other (Specif			natory or other place	Mem. 4-1-	oate O6	20c. Location - C		
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ñ	permit. Departr Importe eny Inje		Harryh R. 1	Valter		March F.H			E. North		
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Vit	sicier certif recto	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death	(Check only o	one)		
o	Phys r this ral di	- L	1 Yes 2 10	1 L Inpatient		1 3 DOA	4 Nursing Hon		dence 6 Other		)
on	ding P h. After t funera	tion	Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) Injury	Worl	Yes 2 □No	.ad. Describe	how injury occurred	1	
Division	I or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		- At home, farm, str (Specify)			8f. Location ( City or To	Street and Number wn, State)	or Rural	Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of rainer: On the basis of example and manner stated	camination and/or inv	occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the	cause(s) and mann date and place, an	ner as sta d due to t	ted. the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier		. ^	29c. License	number		29d. Date signed (	Month, D	ay, Year)
)	1		> MHClas (C	-	M. D.	100	5845	7	MARCH	28	2006
	6		30. Name and address of person who	completed cause of deat	th (Item 23a) (Type,	Print)	3	/			
	7		NAMA CEASAM	821	NORTH	EVTA	U STRE	E7	BALTIA	ORE	2006
	Sta Registr	1.0	31. Date filed (Month, Day, Year)  MAD 3 0 2006	32. Registrar's	Signature	Ī					

Registrar

Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 28 or 28s-f show any injury or other traumatic avant. If a Madical Examinat must be notified at once.	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires that the deeth certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettending physician and policy completely filled in by the funeral director, page 2 should be detached for use as the burial-transit policy completely filled in by the funeral director.	
Divis	To the Hospital or Attending Physicier within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral directo	

Funeral Director

		1 - For State Registrar	State	of Marylan		artment rtificate				lental H	ygiene Reg. No	a come office con	100	202
hysici	an	Decedent's Name (First, Middle,								2. Date of D	Death Da	y Year	3. Time	of Death
/Medic		Lillian R.				1				March	21,	2006	12	РМ
Examin	er	4a. Facility Name (If not institution,				4b. City, 1		Location	of Death			. County of Dea		
uneral		Waldorf Health 5. Social Security Number	icare Cei	7. Age (In yrs.	last birthday)	Wald		If Under	24 Hrs.	8. Date of B		Charles	thplace (State	or Foreign
rector		578 05 7493 Usual Residence of Decedent	1□M 2∏F XX	86	Yrs.	Months	Days	Hours	Min.	(Month, i	25,	1919 S	ountry)	
how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside	City Limits
Sa-fa	Director	Maryland Charl	es		Wald	dorf				_			1 🗆 Ye	s ZNNo
or 2	금	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of What C	ountry?	
n 23e		4022 B Night			2 140			2060	<u> </u>			Jnited S		
important; if tam 27 is marked other than "naturat, or frams 23s or 25s-t anow any injury or other traumatic avant, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed ▼▼ Divorced	Armed F	NO XX BYI		Was Decede If Yes, speci 1 Tyes 2	fy Cubar	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or N Rican, etc.)	No-	14. Race - Am Black, Whi Specify:	te, etc.	
atura cal E		15. Decedent's	Education		16a. Dece	dent's Usual	Occupa	ition			16b. K	ind of Business	White	
the Med	ompleted	(Specify only highest	1	(1-4or 5+)	life.	kind of word DO NOT use Les Re	e retired)	}	t of worki	ing		Clothing		
othe	Se C	17. Father's Name (First, Middle, La	est)						er's Name	e (First, Midd				
utic a	ToB	Cecil Eric No	ewman						Li	illian	Jane	Reece		
auma	( )	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a	nd Numb	er or Rura	al Route Num	ber, City	or Town, State,	Zip Code)	
ner tr		Lynn W. Headley	(P.O		140	Jeffe	rson	Ave	. Loc	cust G	rove,	Va 225	608	
to of		20a. Method of Disposition 1 ☐ Burial 🏖 🖫 Cremation	Removal from		Place of Dispo semetery, cres	sition (Nam	e of			Date		ocation - City or		
r v		4 □ Donation 15 □ Other (Spe	icity)		e Crem	atory	Ma	rch	23, 2	2006	C1i	nton, M	ID 207	35
any in		21. Signature of Funeral Service Li	ansee	100257	. 22	Alexa	Addres:	s of Facili	<sup>by</sup> Lee	e Funer Rd, Cl:	ral H inton	ome,Inc	6633	O1d
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that	caused the deatl	h. Do not ent								Approxim Interval B	ate etween
ician		Immediate Cause (Final disease or condition		700	ONAT	A 4	5/7	14	de.	ease.			Onset and	
lical		Due to (or as a consequence of):												
iner		Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):												3
Sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):				•				•	
s the burial-transit	Examin	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						_			
Duria				(01 43 4 2011304	dence or,									
e II	edical		d						-					
compretely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Teta mant at time of d	Ideath 3	Ectopic pre Other (spe						23d. Date of de Month	olivery Day	Year
deta	by P	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying ca	use give	n in Part I		23e. Did	tobacco i	use contribute t	o the cause of	death?
함										1	Yes 2	□No 3□P	robably 4	<b>J</b> Únknown
ge 2 sho	ompleted	<del></del>									is an opsy	24b. Were a prior to death?	utopsy finding completion of	s available cause of
r. pa	O	05 M								1 ☐ Yes	2/2 No		s 2□No	
recto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	llegation of	ED/C		Othe	r		(Check only		- 74		
eral d	<b>!-</b> !	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		4	4 NU	rsing Hor	me 5 Res 28d. Describe		6 □Other (Speny occurred	ecify)	
the tune	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion (Mo	nth, Day Year)	Injury	М		? ′es 2 ☐	No					
led in by		4 ☐ Homicide determin	buile	e of Injury - At ho ding, etc. (Specif	y) 					City or T	own, State			imber,
pletely fi	edical	29a. Certifier (Check only one)    Certifying   Certifyin	Physician: To the caminar: On the and ma	e best of my kno basis of examina nner stated.	wledge, death tion and/or in	n occurred a vestigation,	t the time in my op	e, date an inion, dea	d place, a th occurre	and due to th ed at the time	e cause(s)	) and manner a d place, and du	s stated. e to the cause	i(s)
con	Σ	29b. Signature and title of certifier						number 24	E		29d. Da	te signed (Mon	th, Day, Year)	
		30. Name and address of person w	no completed cau	ise of death (Item	1 23a) (Type,			0 1				100	<del></del>	
		Howard Haft,		70 Old I	ine Ce	enter.	Sui	te 1	00 V	Waldor:	f, Md			
Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ture	1.2					,			
legistr		MAR 3	0 2008	130000	B.	Gorse	A. Carrier							
Rev 1/20	JV I				€									

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				State of Ma	ryland / Depa				-	ible.	
		•	For State Registrar		•	rtificate of L			Reg. No.	6 0	9809
			1. Decedent's Name (First, Middle,	ast)				2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Betty	Neigh	off			March	26 6	2006	130 PM
	Examir		4a. Facility Name (If not institution, s	ive street and number)	way	4b. City, Town, or	Location of Death		4c. Count	y of Death  AULIA	rove
	Funeral Director		5. Social Security Number 215-14-9853	Sex 1 □ M 2√xF	(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Nov. 7,	th y, Year) 1922	Countr	ice (State or Foreign y) land
	Maryland a-f show	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland	Baltimore	10c. City, Town or Lo	ocation	Balti	more		100	d. Inside City Limits 1 □ Yes 🍇 🙀 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		y?
	th wit	alD	Four Mill Road				21236			USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "natural; or items 23a or 28a-f show mith jury or other traumatic event, it is Medical Examinat must be notified at ONCE.	by Funeral	11. Marital Status  1 Never Married 2 Married  XX Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ 💥 If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes <b>X</b> X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Specia	ce - America ick, White, et fy: Wh	
2-0	72 ho natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of E	Business/Indu	istry
121	within ane. than *	ldu	Elementary/Secondary (0-12)	College (1-4or 5+	)	do not use retired emaker	)		In	Own Ho	ome
о О	filed Hygie other ent, II		8th 17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,			
an	fental fental rked tic ev	To Be	James Archie Lor	ıg			Mildre	d Agnes	Walker		
Maryland 21215-0036	nd 2 shoulth and N		19a. Informant's Name/Relationship Verna Louise Zie	· · · · · · · · · · · · · · · · · · ·		ng Address (Street a			er. City or Town		
Baltimore,	Pages 1 arent of Heanut: if item		20a. Method of Disposition  X		20b. Place of Dispo cemetery, cre Maryland	osition (Name of matory or other place 1 Veteran	e)	Date 4/3/06	20c. Location Garris		
Balti	permit. Departm Importa any inju		21. Signalu 4 o Funeral Service Ui	ensee	Bi	2. Name and Address urgee-Hens 531 Falls	ss of Facility	Funeral	Home,	Inc.	
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or conshock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	- Chy	he death. Do not en	her the mode of dyin	g, such as cardiac	or respiratory a	rrest,	í	Approximate Interval Between Onset and Death
) / ' '	te be executed ysician and ne burial-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	cons * uence of):						
,097	ite be iysicia ne bu	cal		d							
.O. Box 68	at the death certificate by by the attending physistached for use as the b	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy				ate of delivery	y Day Year
S, D	ss this gned se de	by	Part II. Other significant condition	Fib sill	atten	underlying cause giv	en in Part I.		tobacco use cor		a cause of death?
Record	<b>3</b>	Completed	Cereh	10 - Vas	cular	Acci 2	ent-	24a. Was			sy findings available pletion of cause of
H	ian: The la rtificate has ctor, page 2	Co						1 ☐ Yes	2/200		2□ No
Vital	Phyaician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				
of	Phyai this o	2	1 Yes 2 No	I Inpatier		nt 3L DOA	4 Kingursing H		dence 6 Ot		
	ing After une	ntion	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day	Year) 280. Time (	Wor	yat k? Yes 2 □ No	_00. 0000100			
Division	il or Attending after death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 280 Place of Initi	ry - At home, farm, st (Specify)	reet, factory, office			Street and Num wn, State)	ber or Rural	Route Number,
	Hospital 14 hours 2 Funeral tely filled	ical C		Physicien: To the best of saminer: On the basis of							

29c. License number 10611401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ziad WirzarSGO 10ch 2aven 31vd)

31. Date filed (Month, Day, Year)

32. Registrar's Signature Ballimore, UMS 21239

State Registrar

MAR 3 0 2006

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

3 / 28/ 200 6

MARK NOVAK 06-02139 RKD

)		Unpend item#23a,27	berMe C54, 4/13/06/ State of Maryland/		artment of F rtificate of			iene	00010
Physic	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
/Medi	cal	MARK A. NOVAK					MARCH	27, 2006°	4:30P. M
Exami	ier	4a. Facility Name (If not institution, give s 1028 CAYER DRIVE	street and number)		GLEN B	or Location of Death URNIE		4c. County of Deat	
Funeral Director		5. Social Security Number 6. Sex 214-98-2492	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOVEMBER	9. 8in 19,1965	hplace (State or Foreign buntry) PHILLIPPINES
anyland •how		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
Ba-f e	Director	MD ANNE ARUN	DEL GLEN	BURN	IE				1 ☐ Yes 2 ₹ No
death with the Maryland ime 23a or 28a-f ehow rinual be notified at	Die	100. Street and Number			10f. Zip Code 21061		10	ng. Citizen of What Co USA	ountry?
death me 23	Funeral	1028 CAYER DRIVE  11. Marital Status	12. Was Decedent Ever in U.S.	13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian.
and 21215-0036  be filed within 72 hours after death with the Maryla nat Hygiene.  ed other then "naturel", or iteme 23a or 28a-f ehovent, the Madical Examiner inust be notified at	þ	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		f Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)	Specify: WH	e, etc.
15-C	lete	15. Decedent's Educ (Specify only highest grade	cation 16a	(Give	lent's Usual Occup	during most of work	ing	6b. Kind of Business/	Industry
d 212 filed withi Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired JERK	2)		GAS STATIO	N
Maryland 212: nd 2 should be flied within the and Montal Hygiene. 27 is marked other then treumatic event, the Montal Control of the Control	To Be C	17. Father's Name (First, Middle, Last) FRANK NOVAK				18. Mother's Nam	e (First, Middle, M CANNAN	faiden Surname)	
ore, Maryla		19a. Informant's Name/Relationship (Type						City or Town, State, 2	(ip Code)
2 a a a	1	MIKE NOVAK / BROTH		1	DISNEY RD		N, MD 211		To 01-1
Baltimore, permit. Pages t at Department of Hea Importent: if item eny injury or other		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	cemete	ry, cren	TER	a) ΜΛΌΓΙ	I 30	Oc. Location - City or	
altin		21. Signatur Service Lines			FER . Name and Addra:		006 5	TEVENSVILI I SECONI	LE, MD D AVE. SW
<b>m</b> 88 5 8		23a. Part/. Enter the disease, or complice shock, or heart failure. List only on	M01411			FUNERAL H		GLEN BUI	RNIE, MD 2106
Physician /Medical Examiner partial-transit partial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, family cause Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					Onset and Death
Box 68 death certifica e ettending ph	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
ords, P.O	d by P	Part II. Other significant conditions conf	ributing to death but not resulting i	n the un	derlying cause give	en in Part I.		acco use contribute to	the cause of death?
I Rec	Completed						24a. Was an autopsy perform	prior to o death?	opsy findings available ompletion of cause of
of Vital F Physicien: Th this certificate	Be	25. Was case referred to medical examiner?	ospital:		104	26. Place of Death		)	
Of Phys or this eral di	2	1 X Yes 2 No 127. Mapper of Death	1 Inpatient 2 EH/O	tpatient		4   Nuising no	me 5 Residen 28d. Describe how	ce 6 DOther (Spec	(fy) SCENE
nding lath.	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury	28c. Injury Work M 1 🗀	(? Yes 2 □ No		injury occurred	
Division of Vital to a total and the determined the destruction of the destruction of the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director, put the funeral director director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, office	:	281. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number.
Division of Vita Yothe Hospital or Attending Physicien: within 24 hours elfer death. To the Funerel Director: Afler this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 ☐ Certifying Physical Examination	cian: To the best of my knowledger: On the basis of examination are and manner stated.	e, death	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
Tot. Within Tot.	Σ	29b. Signature and title of certifier	. 000		29c. License			d. Date signed (Month,	1 1
	-	Tabrica W	renica-tolle	1 m	2	C.M.E.	MA	ARCH 28, 20	006
X		39-Yame and address of person who com ATR (C. A. Year) 31. Date liled (Month, Day, Year)	apleted cause of death (Item 23a)			STREET BA	ALTIMORE,	, MARYLAND	21201
Sta Registra		MAR 3 0 200	82	do	who				

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	Q Dbini		1. Decedent's Name (First, Middle, Last)		n I			2. Date of Deat		Year	3. Time of Death
	Physici /Medic		suzanne l	)	Price			March		2006	12:00 4 M
	Examin	er	4a. Facility Name (If not institution, give s			•	Location of Death		4c. County o		_
			Howard County Ge		-	Columbi		T	Howa		
	Funeral Director		5. Social Security Number 6. Sex 216-16-9116	M 2∏XF 7. Ag	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Counti	ace (State or Foreign
			Usual Residence of Decedent		0.5			Aug. 19	,1921 N	Mary1	anu
	yland how	.	10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limits
	e Ma	cto	Maryland Howard		E11	icott Cit	у				1 ☐ Yes 2 ☑ No
	ith th or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	hat Countr	ry?
	ath w		4202 Bright Bay N			21042			U.S.A		
	itam itam	Funerai	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Armed Forces?	1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ul> <li>America</li> <li>White, et</li> </ul>	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Meulcal Esarcher must be recitived at	by F	3 Midowed 4 □ Divorced	1 ☐ Yes 21€1 If Yes, Give Year or Dates:		☐ Yes 2 <b>X</b> XNo	Specify:		Specify:	B1a	ck
ğ	2 hou	ted	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bus		
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Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant. The Medical Exarcical mast ke redified at	Be	17. Father's Name (First, Middle, Last)  James Steward Days	C			18. Mother's Nam			-	
ž	hould d Mer marke	욘	19a. Informant's Name/Relationship (Typ		105 14-10-	- 4-1 (211-		he Moore			
Ma	d 2 s th an t7 is t		Alice Pinderhughes			g Address (Street a Hilton R		timore, ]	-		*
ē,	Heal Heal tam other		20a. Method of Disposition	(TIICHU)	20b. Place of Dispo-	sition (Name of		*ATTACAMENT	20c. Location - C		
m 0	Pages ent of nt: If i		1 😾 Burial 2 □ Cremation 3 □ Re  `4 □ Donation 5 □ Other (Specify)	moval from State	Columbia	Momorial	´ 1	-2006	Columbia	Mo	1 d
altimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other once.		21. Signature of Funeral Service License	9,		Name and Addres			Columbia	i, Ma	Tyland
m	Departing any in		My MSK. Hau	kma-	~ W:	itzke Fun 555 Twin	eral Home Knolls Ro	es, Inc.	umbia. M	fary1	and 21045
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each li	the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition		011	vosular					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		9	44			,
		-	Sequentially list conditions, b.	Otto to Large	a consequence or;	Fbrillas				/	nonths
Γ	petr lisit	mine	cause. Enter Underlying Cause (Disease or injury	040 10 (01 44	Carette	myapathe					
·	execunand nand ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequence of):	myapara	<del>y</del>				Tears
8760,	cate be executed physician and the burial-transit	dicai	d.								
9	rtifica ng ph as th	Med	IF FEMALE:								
Вох	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1 Live birth		Ectopic pregnancy			23d. Date		
0.	ne des the al	/sici	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Mont	n D	ay Year
<u>α</u>	that the di ed by the detached	Ph	Part II. Other significant conditions cont	ributing to death b	ut not resulting in the ur	iderlying cause give	an in Part I	23e Did tob	acco use contrib	oute to the	cause of death?
Vital Records,	uires sign	d by			<b>.</b>	adding addition give				Probat	
COL	w requir been s should	Completed						24a. Was ar	n 24h W	ere autons	sy findings available
Re	The lav	шо						autops	y pri ned? de	or to comp ath?	pletion of cause of
ta		0	25. Was case referred to medical				26. Place of Deat			Yes 3	No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	spital: Inpatie	nt 2 ER/Outpatien	3□ DOA Othe	or: 4 Nursing Ho			(Specify)	
0 _	ding Ph th. After th funeral	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injui	y Year) 28b. Time of Injury	28c. Injury Work	at	28d. Describe ho			
sio	Attanding or death. actor: After by the fune	cati	Accident investigation  3 Suicide 6 Could not be				fes 2□No				
Division of	5 5 th 6	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Sti City or Town		or Rural I	Route Number,
	spital		29a. Certifier 1 Certifying Physi	cian: To the best	of my knowledge, death	occurred at the tim	e date and place	and due to the ca	use/s) and man	ner ac ctat	and and
	To the Hospital or Attant within 24 hours after deatl To the Funaral Diractor: completely filled in by the	edical									
	To the within To the comp	M	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed	(Month, Da	ay, Year)
}	ı		11/1			D-53	636		March	26,	2006
	12		30. Name and address of person who con	pleted cause of d	eath (Item 23a) (Type, I	Print)	0 1	/			
	1 4	75	31 Date filed (Atouth Day Your)	CSON, de	10900	charter D.	r. Collins	hia Mo	1 2104	4	
*	Sta Registr		31. Date filed (Month, Day, Year)  MAR 3 0 20	06 July 1	ar s signature	series					
		7	mill o o E	1000							

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2006

Please Type or Print in Black Indelible Ink.  Amend item 20b per fh g853 3-30-06 vt.  State of Maryland / Department of He	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Medical Certification;	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifications) To the best of my kno iner: On the basis of examina and manner stated.	y) 	h occurred at the tim vestigation, in my op 29c. License	e, date and place, inion, death occuri	City or Tow and due to the red at the time,	vn, State) cause(s) and m	anner as st and due to ad (Month,	the cause(s)	
After this certificate has funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify	y) 			City or Tox	vn, State)			
After this certificate has funeral director, page 2											
28	P	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	f 28c. Injury Work	- Indianing no				Residence 6 □Other (Specify) ribe how injury occurred		
28	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deatl			(2		
8 C	Completed	- Myferf	arallypor	teim	<b>L</b>		24a. Was autop perfor 1 Tes	rmed?	prior to cor death? 1 Yes	osy findings avail npletion of cause 2 No	
been signed t should be det	by	Part II. Other significant conditions co  — Dealel	es mellilus arathyrori				d 1□Y	'es 2□No	3 Prob	ably 4 XUnkn	
by the attending ached for use a	Physician/Med	in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	Ideath 3 = eath 5 =	Ectopic pregnancy Other (specify)	n in Part I	23e Did to	Мо		ry Day Year e cause of death	
physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du	Low Jence of): Nea Jence of): brow	nay cer it fails oscular	vez <del>o</del> l vere dese <b>o</b> s	e e e e e e e e e e e e e e e e e e e				
sician edical miner		23a. P. rt1. Enter the disease, or complete, or heart failure. List only of Imms, late Cause (Final disease or condition resulting in death)	no cours on each line					rest,		Approximate Interval Between Onset and Death	
Important: If it eny injury or o once.		21. Signature of Funeral Service Livering	et		739 Baltin						
ant: If item 2 ury or othar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pl ce Removal from State	lace of Dispo emetery, crem ropolit	sition (Name of natory or other place an Cremato	ry 3/25	<b>2006</b> / <del>2005</del>	Alexan	city or Too	<sub>vn, State</sub> Virgini	
tra .		19a. Informant's Name/Relationship (Ty			g Address (Street ar						
c event,	To Be C	17. Father's Name (First, Middle, Last) Smith Leroy Putn	am			18. Mother's Name Jane C	(First, Middle, Carroll	Maiden Suman	70)		
marked other then "natural, or tems 24s or 26s" snow imatic event, the Medical Exert at most be notified at	Completed	(Specify only highest grad	College (1-4or 5+)	life. L	kind of work done du DO NOT use retired) ntract Cle	eaner		Gene	ral	ntenenc	
cal Exern	þ	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates: WWI]	16a. Deced	lent's Usual Occupat	ion	20	Specify 16b. Kind of Br	Whi		
DBC DIAM	Funeral Directo	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 ☐ No	3. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto l	ecify Yes or No- Rican, etc.)	14. Rac	e - America ck, White, e		
Jan or 2	i Dire	10e. Street and Number 3827 Thornwood R	oad		10f. Zip Code 20784		1	U.S.A.		ry /	
office and	ctor	Maryland Prince Ge	orge's Hyat	ttsvil				On China of 1	Athan Cause	1 ▼ Yes 2 □	
Appli		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	cation		1011011	, 1910		d. Inside City Lir	
neral ector		5. Social Security Number 6. Sept 12-3628	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 1	Year)	9. Birthpla Count Mary		
	er '	Ha. Facility Name (If not institution, give s  Doctor 's Communit			4b. City, Town, or L Lanhar			4c. County		rge's	
xamine	al .	WOODROW THOMP					March	1		12:25A	
hysicia /Medica xamine		Stata     Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Vear	3. Time of Deat	

-		1 - For State Registrar	State of M	aryland / Der	partment of Fertificate of			iene Z.No.	09815
Physic	cian	1. Decedent's Name (First, Middle, L.					2. Date of Dear Month		3. Time of Death
_ /Med	ical	Billie Lou Pars  4a. Facility Name (If not institution, gi			45 Chr Tourn	a Location of De	March	29 2006 4c. County of E	
Exam	iner	Manor Care-Rux		'	4b. City, Town, o		<del>g</del> atn	Baltime	
Funera		C. Carial Canada Number	Cau 7 A	ge (In yrs. last birthda	) If Under 1 Year	If Under 24 F	drs. 8. Date of Birth	9.	Birthplace (State or Foreign
Directo			1 M 2 X	86 Yrs.	Months Days	Hours M	June 29		NC
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Maryi -f eho	to	PA Y	ork	S	tewartsto	wn			1 ☐ Yes 2 No
n the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	it Country?
th wit	aiD	16955 Fairfield R	d.		17363			USA	
er dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	. Was Decedent of I If Yes, specify Cub		(Specify Yes or No- lerto Rican, etc.)		American Indian, White, etc.
rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Ovivorced	1 Tes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐No	Specify:		Specify:	white
5-0036 72 hours after death with the Maryland naturel; or Heme 23a or 28e-f ehow attack Exemples in the motified at the second of the second or the second of the second o	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation	v.,	16b. Kind of Busin	ess/Industry
within 7 see.	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or	life	re kind of work done DO NOT use retire	d) d)	working		
d 21 filed wi Hygien pht. the		6th	n/a	Но	memaker	10 14-15-4-1	Name (First, Middle, I	Ow	n Home
and the find He dot	Be	17. Father's Name (First, Middle, Las	()						
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan Fheath and Mental Hyglene. If health and Mental Hyglene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at	J.	Lucian Stewart  19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ling Address (Street		nie Godwii Rural Route Number		ite, Zip Code)
and 2 and 2 m alth a m 27 le		Sandra C. McCor	mick/daug	hter 20	Broadlea	f Ct I	Parkville,	MD 2123	ш
of Head		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		20b. Place of Dis				20c. Location - Cit	
Page Ment ant l		4 Donation 5 Other (Spec			Valley Me		Gardens 7	Cimonium	. MD
Baltimore, permit. Pages 1 a Department of Hee Important: If them eny Injury or othe		21. Sinklyry of Funeral Sey ice Dis	- To	_	22. Name and Addre	ss of Facility			Valley, Inc. 21093
		23a. Part1. Enter the disease, or con shock, or heart failure. List ont	molications that cause one cause on each l	d the death. Do not e	nter the mode of dyi	ng, such as card	diac or respiratory arr	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Acrile	Cereh	evascu	Car 1	Inembu	Ses	Onset and Death
/Medica Examine		resuming in death)	Due to (or as	frome (see					1 longas.
	ē	Sequentially list conditions, if any, leading to immediate	D	a consequence of):					
outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
8760, \alpha are be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
. Box 68760,  death certificate be executed  the attending physician and  ad for use as the burial-transit	dicai		d						
Box 61 leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date o	f dollaron
Box leath cert attending	cian	23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 X No	1 Live birth	2 Fetal death 3	☐ Ectopic pregnanc	у		Month	Day Year
P.O. het the day the day the fetached	hysi	9 Unknown	9 Unknown						
	by P	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribu	te to the cause of death?
cord w require been signal	ted						1 Y	es 2□No 3[	Probably 4 Unknown
Records, the law requires to the has been signe ege 2 should be o	Completed						24a. Was a autops	y prio	re autopsy findings available r to completion of cause of
r. The							perform 1 Yes	ned? dear 2 No 1 □	Yes 2□ No
of Vital Physician: 1 r this certifical	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		ott out		Death (Check only on		
on of Vital Reding Physician: The In. After this certificate he funeral director, pege	n: To	27. Manner of Death	28a. Date of Inj. (Month, Da	ent 2 ER/Outpati ury 28b. Time	of 28c. Inju	4 Nursin	g Home 5 Reside	ow injury occurred	Specify)
Vision Attending r death. ector: After	atio	1 Datural 5 Pending 2 Accident investigati	on	ay Ye <i>ar)</i> Injury		rk?  Yes 2 □ No			
5 5 5 5 E	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (St City or Town		or Rural Route Number,
Divisit  To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examination and/or	ath occurred at the ti investigation, in my o	me, date and plants	ace, and due to the cocurred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
o the	Med	29b. Signature and true of certifier	2/	ialeu.	29c. Licens	se number	2	9d. Date signed (A	Month, Day, Year)
r s ⊢ σ		) ///Ca	lon		2-	0012	849	3-24	-06
2		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)				1D 2120cg
S	tate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1	, 4	-		
Regis		31. Date filed (Month, Day, Year)	General	Dr. Japan					

			1 - For State Registrar		State of M	aryland / De	partmei <i>ertifica</i>				lental Hy	gien Reg. N	11116	09816
	* * * ×		Decedent's Name (F	irst, Middle, Las	t)						2. Date of De	ath		3. Time of Death
, con	Physici		Norma	Marie	Parks	3					Month 3	29	ay Year 2006	
	/Medic Examin		4a. Facility Name (If no	t institution, give	street and number)	1	4b. City	, Town, or	r Location	of Death		4	c. County of Dea	ath
			Genesis H	Eldercar	e		9	Sever	na P	ark			Anne A	runde1
	Funeral		5. Social Security Numb			ge (In yrs. last birthd	y) If Unde	er 1 Year		r 24 Hrs.	8. Date of Bir (Month, Da	th Vea	9. Bi	rthplace (State or Foreig
D.	Director		216-16-558	7	∃M 2□XF	82 Yrs	Months	Days	Hours	IVIIII.	4-13-2	3		MD
	pu ,		Usual Residence of De	cedent b. County		140.00								T
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow or other traumatic event, the Mcdical Examinar must be notilied at	Funeral Director		Anne Aru	nde1	10c. City, Town o	rna Pa	ırk						10d. Inside City Limits 1 ☐ Yes 2 ☐XN
	in the	ire	10e. Street and Numbe	er			10f. Zi	p Code				10g. C	itizen of What C	Country?
	23a c	aiD	24 Truckh	nouse Ro	ad		ŀ	21	146				USA	
	dea	ner	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	3. Was Dece	edent of H	ispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	>-	14. Race - Am Black, Wh	erican Indian,
Maryland 21215-0036	urs aftar al', or Ita	by	1 Never Married 3 XWidowed 4	_	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No	1 ☐ Yes		Specify		riouri, oto.)		Specify:	white
Ą	2 hou	Completed	15.	. Decedent's Edi	ucation	16a. De	cedent's Usi	ual Occup	ation			16b.	Kind of Busines	s/industry
212	hin 7	pie	(Specify of Elementary/Seconda	only highest grad	College (1-4or	(G lif	ive kind of w e. DO NOT i	ork done d use retired	during mo 1)	st of work	ng			
2	d with	E o	unknown		0011090 (1 401		home	make	r			h	ome mak	er
2	ould ba filed v Mental Hygie arked other t atic event, th	Be	17. Father's Name (Firs	st, Middle, Last)					18. Moth	ner's Name	(First, Middle	, Maide	n Sumame)	
<u>a</u>	Aenta Aenta riked	ToE	Harry Det	ter						E1ea	nora F	1yn:	n	
an	should and Men marke umatic		19a. Informant's Name	Relationship (T	ype, Print)	19b. M	ailing Addres	s (Street	and Numi	ber or Rura	I Route Numb	er, City	or Town, State,	Zip Code)
	alth a		Mrs. Nora	DeGrang	e / daugh	ter 205	Secon	d Ave	e SW	G1en	Burnie	MD	21061	
e e	of He Item		20a. Method of Disposi			20b. Place of Di	sposition (Na	me of	ce)	[	Date	20c. l	Location - City o	r Town, State
Ĕ	Page Pent c int: If		1 ☐ Buriat 2 ☑ C 4 ☐ Donation 5 ☐		Removal from State )	Chesape			′	3/29	/2006	St	evensvi	lle, MD
Baltimore,	parmit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra gnce.		21. Signature of Funera	al Service Licens	500	M01357	22. Name a l Seco				ngleton n Burni	Fu.e M	neral H D 21061	ome P.A.
	* W		23a. Part1. Enter the d	disease, or comp	lications that cause	d the death. Do not								Approximate
	Dhysisian		Immediate Cause (Fina		one cause on each I	ne.	145	117	r.	1411	.10			Onset and Death
100	Physician /Medical		disease or condition resulting in death)	-	a. Duato (or as	a consequence of):	IV 12	114	- 1	1716	11-12			Chemon
	Examiner	1		- 1	C. H. Rui		STRUC	i VB	$\mathcal{P}_{\iota}$	II MU	WARY	0	CRACA	240 m
		er	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin	ions, ediate		a consequence of):				( ) ( )		01	- 12 - 13 - 2	31,201
1/	utad	Examiner	cause. Enter Underlyir Cause (Disease or inju- that initiated events	ng iry	_									
Š	icate be executad physicien and the burial-transit	Еха	resulting in death) Last	t I	Due to (or as	a consequence of):								
8760,	sicie b bur	dical		•	d									
89		edi			•									
ŏ	thet the death certificated by the attending a detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outcome		o.□c .						23d. Date of de	alivery
Vital Records, P.O. Box	death a atte	icla	in the past 12 mor	eths?	4☐Pregnant a		3 ∐Ectopic p 5 ∐ Other (s						Month	Day Year
O.	the oy the	hys	9 □ Unknown		9⊟ Unknown									
	s their	by P	Part II, Other significan				underlying	cause give	en in Part	1.	23e. Did t	obacco	use contribute	to the cause of death?
B	w requires their spension of the spension of t	pe pe	VASCUL	AR 1	DRMRNI	7/4					10	Yes a	2 □ No 3 📴	robably 4 Unknown
8	w rec	Completed									24a. Was	an	24b. Were a	utopsy findings available
æ	he law e has i	mc										ormed?	death?	
g	ilcian: Th certificate rector, pag	C	25. Was case referred	to medical					00 51-	( D 1)	1 Yes	2	6 1∐Ye	s 2 No
5	slcia cert irect	<u> </u>	examiner?	_	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpa	tions 200	OA Oth		_	Check only		6 □Other (Sp	( )
ō	Phys r this aral di	. To	27. Manner of Death		28a. Date of Inju	ury 28b. Tim		28c. Injun Worl			28d. Describe			өспу)
o	ding th.	tior	1 □Naturat 5 2 □ Accident	Pending investigation	(Month, Da	ny Year) Inju	у м		k? Yes 2.[				•	
Division of	deal deal ctor	fica	3 ☐ Suicide 6	Could not be	28e. Place of In	jury - At home, farm,	street, facto	rv. office			28f. Location (	Street a	and Number or F	Rural Route Number,
Ē	after after Dire	Certification:	4 🗌 Homicide	determined	building, e	tc. (Specify)					City or To	wn, Sta	te)	
	Hospital or Attending I 4 hours after death. Funerel Director: After tely filled in by the funer		29a. Certifier 1	Certifying Phy	rsicien: To the best	of my knowledge, d	eath occurred	at the tim	ne, date a	nd place,	and due to the	cause(	s) and manner a	is stated.
	To the Hospital or Attending Physician: The law requires thet the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 one)	Medical Exem	iner: On the basis of and manner st	of examination and/o	investigation	n, in my o <sub>l</sub>	pinion, de	ath occurr	ed at the time,	date a	nd place, and du	e to the cause(s)
	Fo th within Fo th	₩ We	29b. Signature and ture	of certifier	71111		29	c. License	e number			29d. D	ate signed (Mon	ith, Day, Year)
	1 0		> let	swee!	W) Acto	indered De	der	7	2160	F4		3/	29/200	06
	Λ		30. Name and address	of person who c	ompteted cause of	death (Item_23a) (Tv	oe, Print)	400			Λ	_/		
	")		CN CY	RIAE.1	4.0 80	21 Rive	113 b	out,	PA	JADO	3NM,	M	() & i()	3 \
7	Sta	te	31. Date filed (Month, L	Day, Year)	32. Pagist	rar's Signature	1	. 1			· · · · · · · · · · · · · · · · · · ·			
	Registr	ar	30. Name and address  OVCY  31. Date filed (Month, I	AR 3 0 21	JU6 1	yes &	Spark	3						
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DHMH 17 Rev 1/2001

		Please 1	Type or Prin State of Ma						-		•		
		1 - State Registrar			Cei	rtificate	of D	eath		Reg.	No.	09817	
Division	· c	1. Decedent's Name (First, Middle, Last							2. Date of	f Death	Day Year	3. Time of Death	
Physicia /Medic		Huestace	M Pouchie						Month 3	24	2006 Year	8:00a h	
Examin		4a. Facility Name (If not institution, give				4b. City, To	wn, or L	ocation of D	eath		4c. County of Dea	ath	
11.4	э <del>й</del> ,	1744 E. Oliver 5. Social Security Number 6. Se		//	- 4 h (-4h -4 1	If Under 1	Baltimore If Under 1 Year   If Under 24 Hrs.   8				N/A		
Funeral Director		265-84-3754	X XM 2□F	66	st birthday) Yrs.		Days		din. (Monti	28-	ear) C	rthplace (State or Foreig Country) Onduars	
and		Usual Residence of Decedent  10a. State 10b. County	1	10c. City,	Town or Lo	ocation						10d. Inside City Limits	
Maryl	tor	Md. NA			Balt	imore						1X Yes 2 N	
28a	Director	10e. Street and Number				10f. Zip C	ode			10g.	Citizen of What C	Country?	
h with		1744 E. Oliver S	treet				2121	3			USA		
deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Deceder	nt of His	panic Origin	? (Specify Yes ouerto Rican, etc.	r No-	14. Race - Am Black, Wh		
be filed within 72 hours after death with the Maryland half Hygiene. Ad other then "neturel", or items 23a or 28a-f show event, the Medical Examinational by notified at	by	1 ☐ Never Married 2 💢 Marned 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	o	1	1 Yes 25		Specify:	dono modif, die	.,		Black	
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ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use	retired)	,gou	y				
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ntai h	Be	17. Father's Name (First, Middle, Last)		-	, .		'		Name (First, M.	ooie, mai			
hould d Me mark matic	ို	Kischner  19a. Informant's Name/Relationship (T)	une Printl	POI	achie	na Addross //	Stroot an	Fran		umber C	Rich ity or Town, State,	Zin Codo)	
1 and 2 should Health and Mer em 27 is mark ther traumatic		Paula Ponchie	Wife						et, Bal			21213	
Heal Heal	1	20a. Method of Disposition	WILC	20b. Pla	ce of Dispo	sition (Name	of		Date Date		Le, Plu.		
Pages nent of I int: If its		1X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,				matory or other	er place,		3-29-06		altimore		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, the Magnes.							Address						
29 E 2 A		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  MARCH FUNERAL HOME-EAST  1101 E. NORTH AVENUE BALTIMORE, MD 21202											
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death.								Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition			ancer	•						7 years	
/Medical Examiner		resulting in death)	Due to (or as a									, years	
pe psit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a conseque	ence of):								
axecul	хап	that initiated events resulting in death) Last	c Due to (or as a	Due to (or as a consequence of):									
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ificate g phy as the	edlo		u										
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thet hed by deta		Part II. Other significant conditions co	entributing to death bu	it not resul	ting in the u	nderlying cau	se giver	in Part I.	23е.	Did tobac	co use contribute	to the cause of death?	
w requires been sign should be	ed by								_	1 🗀 Yes	2 X No 3 □ F	Probably 4 🗆 Unknow	
e law re has bee	Completed									Was an autopsy	24b. Were a	autopsy findings available completion of cause of	
The ate h	E								101	performed	d? death?	,	
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hysic his ce	2	1 ☐ Yes 2 💢 No	Hospital: 1   Inpatie		P/Outpatier	nt 3 DOA	1	4 🛄 Nursa	ng Home 5	Residenc	e 6 ⊡Other (Sp	ecify)	
e fe e	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury		Work?		28d. Desc	ribe how	injury occurred		
death death tor: /	lcat	2 Accident investigation 3 Suicide 6 Could not be	280 Plans of Inju	Inc. At hon	no form at	M Tool factors		es 2□No	286   0021	ion (Strac	at and Number or I	Purel Poute Number	
ital or Attendins efter death	Certification:	4 Homicide determined	building, etc			arm, street, factory, office  28f. Location (Street and Number or Rural Route Nu City or Town, State)							
To the Hospital or Attending within 24 hours elfer death of 10 To the Funerel Director: Alter completely filled in by the fune	29a. Certifier  (Check only one)  29a Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)						, death occurred at the time, date and place, and due to the d/or investigation, in my opinion, death occurred at the time,				he cause(s) and manner as stated. ne, date and place, and due to the cause(s)		
To th Within To th comp	29b. Signature and attle of certifier						29c. License number			29d. Date signed (Month, Day, Year)			
		4				D3	3375	9		03	/24/2006		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Arif Hussain, M.D. 22 South Greene Street N9E08, Baltimore, MD 21201

		1 - For State of Maryla		artment of Health and I rtificate of Death		ene g. No. 0 0 6	09818
Phys	ician	Decedent's Name (First, Middle, Last)     AKHUR ROSE BOROUGH	Arthur F	Roseborough	2. Date of Death Month	Day Yea	3. Time of Death
	dical niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deatl	03.21.	4c. County of De	10.50
	No.	3324 SEQUOIA AVENUE		BALTIMORE		NI	
Funer Directo		213.26.8597 1ªM 2□F 13	rs. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, 05.11-10	9. B 132	lirthplace (State or Foreign Country)  MD
land ow	9	Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Lo	ocation			10d. Inside City Limits
death with the Maryland ms 23s or 28e-f show rmust be collited at	ctor	MD NA BA	LTIMORE	<del>=</del>			1 X Yes 2 □ No
ith the	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What (	Country?
eath v ns 23e	Funeral	3324 SEQUOIA AVENUE  11. Marital Status  12. Was Decedent Ever in	US 13 1	ZIZI5 Was Decedent of Hispanic Origin? (S	nects Ves or No-	USA 14 Bace - An	nerican Indian,
I 3-UU.30 72 hours after death with the Marylan *natural; or Items 23s or 28e-1 ehow edical Examiner must be notitied at	by Fun		1	of Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 □ No Specify:	o Rican, etc.)	Black, Wh	
72 hou	eted		16a. Dece	dent's Usual Occupation	kuna 1	6b. Kind of Busines	
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Vian uld be Mental rked o	70 B	HENRY ROSEBOROUGH		GERTRU	DE BRO	NW	
Mary d 2 sho th and h treuma	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru	58.0	City or Town, State	, Zip Code)
G, 1 an Heal em 2		DORIS ROSEBOROUGH (WIFE)  20a. Method of Disposition	3324 D. Place of Dispo	SELUDIA AVE., I	BALTO. MI	D 21215 20c. Location - City of	or Town, State
0 0 0 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other place)		WINGS IY	
교 등문증	once.	21. Signature of Funeral Service Licensee	VA VA	2. Name and Address of Facility UGHN C. GREENE F	SINEDAL S	REPUICE	IIUS. IVID
n ages	a	23a. Part1. Ente (the disease, or complications that caused the de	\ <u>5</u> l	51 BAUTO, NATE PIKE	E, BALTO.	MD 21229	Approximate
ficate be executed  Medic:  physicien and sthe burial-transit	al er e	shock, or heaft failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to or as a consulting in death) Last  Due to or as a consulting in death) Last	equence of):	reardial,	nfare Nfare	tion	Interval Between Onset and Death  What Death  25 yrg
BOX   eath certiing attending for use a	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  4☐ Pregnant at time of	etal death 3 [	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	delivery Day Year
COTGS, P.O. wrequires that the deben signed by the should be detached	Physi	Part II. Other significant conditions contributing to death but not r	resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rdS, quires to n signe uld be c	ed by	Itemen tensional			1 🗆 Yes	s 2√2 No 3□	Probably 4 Unknown
e la has	dmo	- Congestive It	eart	J-milyre	24a. Was an autopsy perform	1 24b. Were prior to death?	autopsy findings available o completion of cause of ?
r VICAL P. ysician: Th is certificate director, peg	Be	25. Was cash referred to medical examiner?	7/145		ith (Check only one		
n Of ng Phys fter this ineral dil	ion; To		ER/Outpatier 28b. Time of Injury	f 28c. Injury at Work?	lome 5 M esider 28d. Describe how	nce 6 Other (Sp w injury occurred	necify)
E Pige	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - Al building, etc. (Spe	t home, farm, str ecify)		28f. Location (Str. City or Town,	eet and Number or . , State)	Rural Route Number,
the Hospital in 24 hours of the Funeral Inpletely filled	Medical C		knowledge, deatl ination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the car rred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To the comp	M	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Mo.	nth, Day, Year)
10		> monder	W.	D10152		03/2	1/06
W		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print) Redwa	A 5%	Botto	Md. 21201
31	State istrar	31. Date filed (Month, Day, Year)  32. Engistrar's Sig	gnature	nede			

			For State Registrar	State of Maryla		artment of H			giene Reg. No.	06 09819
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Las Bradley Po	(U) r	Zice			2. Date of Dea Month	Day 21	3. Time of Death 2006 1145 f M
<b>)</b>	Examin Funeral	er	4a. Facility Name (If not institution, give University of Mar  5. Social Security Number 6. Social Security Number 1.	yland Medic	. last birthday,	4b. City, Town, or  If Under 1 Year  Months Days	Baltm If Under 24 H Hours Mi	rs. 8. Date of Birt	h y, Year)	ty of Death  A  9. Birthplace (State or Foreign Country)  Newsorks
and box	Director		617-30-0627  Usual Residence of Decedent  10a. State 10b. County		19 Yrs. ity, Town or L	ocation		0ct. 3	,1900	Nebraska  10d. Inside City Limits
the Mary	28a-1 sh	rector	Maryland Howard		Co	olumbia			10g. Citizen o	1 ☐ Yes 2 🔯 No f What Country?
diw c	3a or	Ö	9465 Greco Garth			2104	45		U.S	S.A.
36 Is after deat	il, or items?	by Funeral Director	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2KKNo	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Bi	ace - American Indian, ack, White, etc. i <sup>ify:</sup> Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if them 27 is marked other then "natural", or items 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) College (1-4or 5+)	on 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)			working		Business/Industry
land 2		To Be Co	17. Father's Name (First, Middle, Last) Brad Roderick Ri		<u> </u>		Linda	lame (First, Middle, a Brode	Maiden Suma	ame)
Mary	ulth and h		19a. Informant's Name/Relationship ( Brad Roderick Ri			ing Address (Street Greco Ga:				
more,	or othe	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Memovai irom State		osition (Name of ematory or other place	1	Date		n - City or Town, State
Baltimore,	Departmen Important: eny injury		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licen		1 2	orial Parl 2.Name and Addre Witzke Fuu	ss of Facility	24-2006 omes. Inc		nore, Maryland
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760, <	00 % 00	icai Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to intradistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)	S SC equence of):	rcoma				Interval Between Onset and Death
.O. Box 68	death certific e attending p id for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	y			Date of delivery Month Day Year
<b>a</b> 3	The law requires tha ate has been signed page 2 should be de	ρ	Part II. Other significant conditions of	contributing to death but not re	esulting in the	underlying cause giv	en in Part I.		obacco use co Yes 2 No	ontribute to the cause of death?  3 Probably 4 Unknown
œ ;		Completed						1 ☐ Yes	psy prmed? 2)KJ No	b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
V It	Pnysicien: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	T 50/0.4	Ctt		Death <i>(Check only</i> g Home 5 ☐ Res		Othor (Casada)
on of	ding P. After fune	tion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpati 28b. Time Injury	of 28c. Inju		28d. Describe		
Divis	of or Attend efter death Director: / d in by the f	ertification:	3 Suicide 6 Could not be determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	3		30. Name and address of person who	completed cause of death (III	em 23a) (Typ			ret P		ore, MD 21201
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Sparle				

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	Funeral Director		5.
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Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be filed with Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other ther eny injury or other traumatic event, the MODE.		2
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the 288	John John John John John John John John	10e. Street and Nur	nber				10f. Zip Code				10g. Citize	n of What Co	untry?	
With With	2	115 Mel	rose								U.	S.A.		
ne 2;	2	11. Marital Status		12. Was Decede	nt Ever in U	.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Ori	igin? (Spec	ify Yes or No		. Race - Ame	rican Indian,	_
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irs a	1	3XXVidowed	_	1 ☐ Yes 24 If Yes, Give Year or Date	s:		1 □ Yes 2 🛣 No	Specify:			S	oecity: W	hite	
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ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Heelin and Mental Hygiene.  The fleetin and Mental Hygiene.  The maryland strength of the riben "neture", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified.		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Maili	ng Address (Stree	t and Numbe	er or Rural	Route Numbe	er, City or 1	own, State,	Zip Code)	
ad 2 27 is		Virgini	a Rote	(Daught	er)	235	S. Her	rina	st.	Balti	more	.MD 2	1231	
the Head		20a. Method of Dist	position		20b. F	lace of Disno	osition (Name of matory or other pla		Da			tion - City or		
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				plications that cause on each	n line.	n. Boriot on	or the mode or dy		04,000	rospiratory at			Interval B Onset an	etween
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The The ate h page		ĺ í									2 No	death?	2 No	
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ter th	3			28a. Date of I	njury Day Year)	28b. Time o	f 28c. Inju	ury at	28	d. Describe l	how injury	occurred		
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	Corticolitica	5		ganding.	Oto. (Opcon	,,				,	,,			
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the	1 5			hysician: To the be										(-)
n 24 he Fi	100	one)	2 Medical Exa	miner: On the basi and manner		and/or in	vestigation, in my	opinion, dea	ath occurred	at the time,	date and p	ace, and due	to the cause	(S)
withii To tl	1	29b. Signature and	title of certifier	/)			29c. Licen	ise number			29d. Date	signed (Mont	h, Day, Year	
^		1	Ul	- MEDI	CALRE	ESIDIEN	- RES	5-00	0	и	MARCH	,18 2	006	
17	-	30. Name and addr	ess of person who	completed cause							.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,000		
		RYAN TI					STREET, B	ALTIM	RE I	MARYLAN	10 21	287		
	State	04 D + 40 + 414		23%Pag	ictrar's Signs	aturo -			- / /'					
Regi			AR 3 0 20	06	کر رہ	A SOL	ME							
		2111												

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			For State Registrar	State of Maryland	•		f Health a of Death	ind Mental	Hygier	0000	09822		
for 3	Physici	an	1. Decedent's Name (First, Middle, Las Maude Eliza	ubeth Schult	-7			Mont		Day Year 3, 2006	3. Time of Death		
	/Medic		4a. Facility Name (If not institution, give		dany	4b. City, Tow	n, or Location o	Mac f Death		4c. County of Dea	ath		
			5008 Silver Spi				y Hall			Baltir			
	Funeral Director		5. Social Security Number  2 \( \frac{1}{2} - \frac{36}{36} - \frac{9706}{9706} \]  Usual Residence of Decedent	2 Age (In yrs. I		If Under 1 You Months Da	ear If Under 2 ays Hours	Min (Mon	of Birth th, Day, Yes	ar) 1940 M	rthplace (State or Foreign country) ary and		
Maryland	Maryland -f ehow lied at	tor	10a. State 10b. County Maryland Baltin		1, Town or Lo	cation Hall					10d. Inside City Limits 1. Yes 2 □ No		
	with the	Direc	10e. Street and Number 5008 Silver	Spring Rd.		10f. Zip Cod	de 21128		10g.	Citizen of What C	Country?		
36	be filed within 72 hours after death with the Maryland nat lyylene. Id other then "natural", or teme 23a or 28a-f ehow event. The Medical Evantaer must be rediffed at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			of Hispanic Orig Cuban, Mexican	gin? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Am Black, Wh	ite, etc.		
21215-0036	within 72 hou ene. then "natura	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) บทหูกอเมล	ucation	(Give life.	dent's Usual Ockind of work do	one during most atired)	of working		Kind of Busines:			
73	should be filed within nd Mental Hygiene. marked other then umatic event. It is Me	To Be Co	17. Father's Name (First, Middle, Last) Francis O. Gris	mm, Sc.				r's Name (First, M Sarah		den Sumame) Cougle			
Mary	s 1 and 2 should f Health and Men Item 27 le marke other traumatic		19a. Informant's Name/Relationship (1) Elizabeth A. Currey /			•		ror Rural Route I		ty or Town, State,	Zip Code)		
d)	ages 1 an of Healing 1: If Item 2		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	lace of Dispo emetery, crer	sition (Name o natory or other	place)	Date	20c	Location - City o			
Baltimore,	permit. Pages of Department of Hisportant: If the any injury or of once.		4 ☑Donation 5 ☐Other (Specify  21. Signature of Funeral Service Licen		tomy Git	ts Regise. Name and Aratomy	114	istry se solte P					
>,0928	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	er the mode of	dying, such as	cardiac or respira		ncar	Approximate Interval Between Onset and Death Wonstus		
P.O. Box 687	death certificate e attending phy od for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1	Ideath 3	Ectopic pregn				23d. Date of d	elivery Day Year		
	uires that the signed by ald be detacted.	by	þ	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause	e given in Part I.	23e	Did tobacc		lo the cause of death?  Probably 4 □Unknown
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed							Was an autopsy performed Yes 2 12	prior to death?	autopsy findings available completion of cause of s		
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death Check	/				
ou of	Attending Physic death.  ctor: After this by the funeral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Injury at Work?	28d. Des		e 6 □Other (Sp njury occurred	ecify)		
Division	i Diffe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, of	fice		ition (Street or Town, St		Rural Route Number,		
	the Hospital hin 24 hours of the Funeral higheren filled	edical C	29a. Certifier (Check only one)	ysician: To the best of my kno niner; On the basis of examinal and manner stated.	wledge, deat tion and/or in	n occurred at the	ne time, date an my opinion, deal	d place, and due th occurred at the	to the cause time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)		
)	To th withir To th comp	Me	29b. Signature and little of certifier		n - D .		cense number	10	M	Date signed (Mor	24 2000		
	5		30. Name and address of person who	completed cause of death (Item	123a) (Type,	Print) A Roa	d # 20.	8, Bal	time	ore, M	D 21236		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 3 0 2	32. Registrar's Signa	iture 1	bark							

			For State Registrar	State of M	•	partment o ertificate		and Mental H	ygiene Reg. No.	6 09823
			1. Decedent's Name (First, Middle,	Last)				2. Date of I Month	Death Day	3. Time of Death
	Physicia /Medic		Norman	Victor	5	Stephens		MAR		006 10: 30 AM
	Examin		4a. Fecility Name (If not institution,	give street and number)		4b. City, To	wn, or Location	of Death	4c. County	of Death
		٠	Future Care Che	esapeake			no1d		Anne	Arundel
	Funeral		5. Social Security Number 216–18–7940	6. Sex 7. Ag 1X M 2 F	ge (In yrs. last birthd	Months   D	Year If Under Pays Hours	Min. (Month, I	Birth Day, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		82 Yrs			Aug.	21,1923	MD.
	and w		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	Į.	MD. Anne An	rundel	Arno1d					1 ☐ Yes 2 X No
	the 28a-	rec	10e. Street and Number		1	10f. Zip Co	ode		10g. Citizen of	What Country?
	3a ol	D	105 Asqith Oaks	s Lane		21	012		U.S.A.	•
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 1			igin? (Specify Yes or ! n, Puerto Rican, etc.)	No- 14. Rac	ce - American Indian,
9	atter or Ita		1 Never Married 2 Marrie	Armed Forces' ed 1 ∑Yes 2 ☐ If Yes, Give	No	1 ☐ Yes 2 🛭			Specif	ck, White, etc.
ဗ္ဗ	72 hours atter death with the Maryland natural', or Itams 23a or 28a-f show dical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:						
7	natu	Completed	15. Decedent' (Specify only highest		(G	cedent's Usual C	done during mos	st of working	16b. Kind of B	usiness/Industry
12	within ane. than	ď	Elementary/Secondary (0-12)	College (1-4or	5+)	e. <i>DO NOT use i</i> al Worke	*		II.S. P	ost Office
2	Hygie ther int,	e Co	12 17. Father's Name (First, Middle, L	ast)				er's Name (First, Midd	1	
an	d be antal ced o	m	Clyde Stephens				Vir	ginia Russ	see	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show amportant: If item 27 is marked other than "natural; or Itams 23a or 28a-f show apprintury or other traumatic avant, the Madical Examinat must be notified at once.	-	19a. Informant's Name/Relationsh	ip (Type, Print) Daug	hter 19b. M	ailing Address (S		er or Rural Route Nurr		, State, Zip Code)
	alth a		Mrs. Norma Step	hens Campbe	11 10.	5 Asquit	h Oaks	Lane Arnol	d, MD. 2	1012
Baltimore,	of He itam itam		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	a DB	20b. Place of Di cemetery, of	sposition (Name crematory or othe	of r place)	April 1,	20c. Location -	- City or Town, State
Ĕ	Page nent ant: If		'4 □ Donation 5 □ Other (Sp			ven Mem	i	2006	Glen Bu	ırnie,MD.
alt	Departr Departr Importa any inj		21. Signature of Funeral Service I	icensee		22. Name and A	Address of Facili	y Singletor	r Funeral	Home, P.A.
<u> </u>	205 20		Mark ll.	Varur				e SW. Glen		
П			23a. Part1. Beter the disease, or shock, or heart failure. List of	complications that cause only one cause on each l	d the death. Do not ine.	enter the mode o	f dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Fnysician		Immediate Cause (Final disease or condition resulting in death)	CERER	ROVASC a consequence of):	ULAR	DISE	EASE		
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		ā	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):					
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):			_		
8760,	ate be executed hysician and the burial-transit	ical		d						
9	.O G W	8	IF FEMALE:							
Вох	eath certif attending for use a	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic preg				ite of delivery onth Day Year
		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	t time of death	5 Other (speci	fy)		•	
P.0	that the doed by the detached		Part II. Other significant conditio	ns contributing to death I	out not resulting in th	e underlying caus	se given in Part I	i. 23e. Die	d tobacco use cont	tribute to the cause of death?
Records,	requires that the	d by	ATRIAL F	IBRILLAT	101			10	]Yes 2□No	3 ☐ Probably 4 ☑ Unknown
COL	> 13 0	lete	CRITICAL	(ABATI				24a. W	as an 24b.	Were autopsy findings available
Re	9 L B	Completed	CRITICAL	C/1 /C8 / 1	575	W0217		p <i>e</i>	topsy normed2	prior to completion of cause of death?  1 \( \sum \) Yes \( 2 \sum \) No
Vital	ician: Th certiticate rector, pag	O	25. Was case referred to medical				26. Place	1 ☐ Yes e of Death (Check only		1 1 1 9 5 2 L NO
<u> </u>		To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpa	tient 3 DOA	0.1	ursing Home 5 🗆 Re		ner (Specify)
n of	ng Phys ter this neral di		27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injur	9 of 28c	Injury at Work?	28d. Describ	e how injury occur	red
Siol	Attanding r death. actor: After by the fune	catio	2 Accident investig	ation		М	1   Yes 2			
Division	or Att	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of In	jury - At hom <i>e</i> , farm, tc. <i>(Specity)</i>	street, factory, o	ffice		(Street and Numb own, State)	ber or Rural Route Number,
	pital ours a aral E	Ce	29a. Certifier 1 Certifyin	Physicien: To the best	of my knowledge, d	eath occurred at	the time, date as	ad place, and due to th	ia causa(s) and ma	anner as stated
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	edical		xeminer: On the basis of and manner s	of examination and/o					
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				icense number			ed (Month, Day, Year)
}			I prenies	, mis		Z	575	3/	MAR	28, 2006
	4		30. Name and address of person v	vho completed cause of	death (Item 23a) (Ty	pe, Print)	0		-	28, 2006 the MD 21101
	2)		nohit Neg	i 8601 L	leterans	Hwy	, Suite	204 14	1llersv10	Ke MD 21101
	Sta Registr		31. Date filed (Month, Day, Year)	OZ. HOGIS	ar's Signature	South	,			
	negisti	ar .	MWU 9	4 7000	NEW YORK	The same of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 MARCH 27, Physician STAINMAN Рм HENRY 5:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB. 18.1913 Birthplace (State or Foreign Country)
 N 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F NJ 141-05-3385 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? USA 8911 REISTERSTOWN ROAD #207 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **AUTO SUPPLIES** OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STAINMAN ROSE WEISS **THOMAS** ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 W. JOPPA ROAD - TOWSON, MD 21204 STUART STAINMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🌣 Removal from State MT. LEBANON CEMETERY 03/29/2006 ISELIN, NJ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Immediate Cause (Final disease or condition resulting in death) **Physician** rears /Medical Due to (or as a consequence of): Examiner CONOMAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ailure Obstructive land 1 Yes 2 No 3 Probably 4 Unknown Completed disease 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate hes t autopsy performed? 1 Yes 2 XNo director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director; Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of pertifier 29c. License number 1)25205 My und

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12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "y

Baltimore, Maryland

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Division of Vital Records,

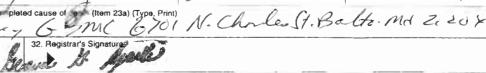
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certificate

STall man,

State Registrar

31. Date filed (Month, Day, Year) MAR 3 0 2006



Robert P. Thorsen 06-20 AKG

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			1 - For State Registrar	Giato C	i waryia		rtificat				Ornar i ij	Reg. No		6	09	825
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of D Month	Da	y_	Year		e of Death
	/Media	cal	Robert P. 7				45 035	T	1		March 23, 2006 5:43  Death 4c. County of Death				3 P M	
	Examir	er	6407 Beachfield		mber)		4b. City,		Location				. County Howa			
	Funeral			Sex	7. Age (In yrs	s. last birthday)	ff Under	1 Year	If Under	r 24 Hrs. Min.	8. Date of Bi (Month, D				ite or Foreign	
	Director		217-74-5697	1 M 2 □ F	47	Yrs.	Months	Days	Hours	MIII.	June :	11,19	958	Kans	as	
	land		Usuaf Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation							1	Od. Inside	le City Limits
	Mary -f sh	tor	Maryland Howard	[	F	Ikridge	е								1 🗆 Y	Yes 2⊠No
	hours after deeth with the Maryland Jural', or Items 23e or 28e-f show at Exaction must be collified at	Funeral Directo	10e. Street and Number				10f. Zip				10g. Citizen of What Country?					
	s 23a	ral	6407 Beachfield					210						S.A.		
_	Items	une	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Dec	edent Ever in orces?	U.S. 13.	Was Deced If Yes, spe	dent of Hi city Cuba	spanic Or n, Mexica	rigin? (Spe in, Puerto l	cify Yes or N Rican, etc.)	0-		ce - Americ ck, White,		١,
20	urs at	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Gir Year or D	ve "-		1 🗆 Yes	2 🗓 No	Specify				Specify		ite	
21215-UU36	72 ho natur	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give	dent's Usua kind of wo	rk done d	turina mos	st of workir	ng	16b. K	and of B	usiness/In		
7	within 72 ene. then "nat	mp	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	<i>ро мот и</i> Salesi	se retired	)				۸ <del>د</del>	m a + i -		
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yland		To Be	Robert Olaf						Bev	erly	Ann Mı	ırphy	y			
Mary	s 1 and 2 should t Health and Mer tem 27 Is marke other treumatic	-	19a. Informant's Name/Relationship				-				l Route Numb					
	l and lealth im 27 her tr		Beverly Ann Murphy (Mother)  3907 Spring Meadow Drive Ellicott City, MD. 2  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State													
ĕ	0 0		1 ☐ Burial 2 🖾 Cremation 3		State	_										
Baltimore,	nit. Pag ertment ortant: I injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service \(\text{ic}\)		⊢Me	tro Cr	-	-			-2006		cons	AITTE	, Ma	ryland
ñ	Ded dim e		MYSK. H	udem	an		Vitzk 5555 '	e Fu: Twin	neral Knol	L Home L1s Re	es, Indo	c. Lumb:	ia, l	Mary1	.and	21045
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	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):	Selo WY	7		2						
Ļ	Ĭ	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause Disease or injury  A Lyper Gastrointcsterial Herrary hage  Due to (or as a consequence of):  Clyper Gastrointcsterial Herrary hage  Due to (or as a consequence of):  Clyper Gastrointcsterial Herrary hage  Due to (or as a consequence of):  Clyper Gastrointcsterial Herrary hage  Due to (or as a consequence of):													
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/00,	te be executed ysicien and ne burial-transit	Ex	resulting in death) Last	Due to	(or as a conse	is of:		pD.								
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XO	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou									23d Dat	te of delive	arv	
ň	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4∐Pregr	oirth 2 ☐ Fe nant at time of		⊒Ectopic pr ∃Other (sp							nth	Day	Year
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ďs,	requires that een signed b nould be dete	ρ	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part	I.		tobacco i		ribute to th 3 ☐ Prob		of death?
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E E	The la ate has page 2	Completed									24a. Was auto perf 1[X(Yes		1 5	prior to co death?	psy findin mpletion ( 2 No	ngs available of cause of
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1XXYes 2 □ No	Hospital:	In-ations Of	750/0		Othe	ar-		(Check only		. 3756		ot c	
ŏ	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time o		8c. fnjury Work	4 🗀 N		ne 5 Res 8d. Describe				/al S	cene
ISION	Attending I r death. ector: After by the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigati	on	th, Day Year)	Injury	М		c? Yes 2□	]No						
	o ii e	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	of Injury - At ing, etc. (Spec	home, farm, st	reet, factory	, office		2	28f. Location City or To			er or Rura	I Route N	lumber,
-1	the Hospital of thin 24 hours along the Funerel Dimbletely filled in	a C	29a. Certifier 1 ☐ Certifying F	hysician: To the	best of my kr	nowledge, deat	h occurred	at the tim	e, date ar	nd place, a	and due to the	cause(s	) and ma	inner as si	ated.	
	thin 24 h	ledical	(Check only At Medical Ex-	aminer: On the b	asis of examir ner stated.	ation and/or in	vestigation	, in my of	oinion, dea	ath occurre	ed at the time	date and	d place,	and due to	the caus	
	2 E E	≥	29h Signature and title of certifier				200	License	number			29d Da	to signa	d (Month	Day Van	er)

State Registrar

31. Date filed (Month, Day, Year) 2006 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

March 24, 2006

O.C.M.E.

Oonald Tennyson 06-2145 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	_
State of Maryland / Department of Health and	d Mental Hygiene	100
Certificate of Death	Don Ma	3 () (

09826

	Physician
	/Medical
)	Examiner

Funera

Directo permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Cei	rtificate of	Death		eg. No.	00000			
Decedent's Name (First, Middle, Last)  In  al	Donald R.	Tenny	son		2. Date of Deat Month March 2	18, Day 2006	ar 8:01 A M			
4a. Facility Name (If not institution, give s Union Memorial Hos				r Location of Death		4c. County of D	eath			
	7. Age (In yrs. 57	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 13,	<sup>y</sup> ear) 48 Ma	Birthplace (State or Foreign Country) Lry Land			
Usual Residence of Decedent  10a. State 10b. County N/A	10c. C	ity, Town or Lo Baltim					10d. Inside City Limits			
10e. Street and Number 3516 Chestnut Ave	nue		10f. Zip Code	21211	1	0g. Citizen of What U.S.A	•			
10e. Street and Number 3516 Chestnut Ave.  11. Marital Status 1 Never Married 2 Married 3 Widowed Worced  15. Decedent's Educ (Specify only highest grade)  10th  17. Father's Name (First, Middle, Last)	12. Was Decedent Ever in U Armed Forces? X1X Yes 2 □ No If Yes, Give Year or Dates:	171	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2007No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. /hite			
15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retired es Clerk	pation during most of work d)	ring	16b. Kind of Busine Retail	ss/Industry			
17. Father's Name (First, Middle, Last) William R. Tennyson, Sr.  18. Mother's Name (First, Middle, Maiden Surname) Lillian Virginia Fowble										
19a. Informant's Name/Relationship (Type Lisa Tennyson (Dau				and Number or Rui wn Circle		City or Town, Stat , MD 212				
20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Place of Dispo cemetery cren cro Cre	sition (Name of matory or other place matory	<sup>(ce)</sup> 03/		20c. Location - City Catonsvi				
21. Signature of Funeral Service Licens	asunt	F <sub>u</sub> <sup>22</sup> 36	Name and Addre rgee—Hens 31 Falls	ss of Facility SS-Seitz Road Ba	Funeral 1to, MD	Home Inc 21211				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.										
Fany, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5 Other (specify)									
Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		oacco use contribute es 2 □ No 3 □	e to the cause of death?  Probably 4 Minknown			
Complete					24a. Was as autops perform	24b. Were prior death	autopsy findings available to completion of cause of 1?  Yes 2 \sum No			
25. Was case referred to medical examiner?	anatal.		100		h (Check only one					
27. Manner of Death  1 Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier  29b. Signature and title of certifier	ospital: 1 Inpatient 22 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	y at	ome 5 Reside 28d. Describe ho	ence 6 Other (S	Specify)			
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str fy)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or , State)	Rural Route Number,			
29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner ate and place, and c	as stated. due to the cause(s)			
29b. Signature and title of certifier	`		29c. Licens	o.C.M.E.	29	9d. Date signed (Me March 2	onth, Day, Year)			
30. Name and address of person who con	10	111	Penn Str	eet, Balt	imore, M		21201			
e 31. Date filed (Month, Day, Year)	22. Registrar's Sign	ature	des.			-				

Registrar

			1 - For Stata Registrar		Marylar		artment of				ag. No.	6	09827
Н	Physici	an	Decedent's Name (First, Middle     Name (First, Middle	, Last)		r2' 3				Date of Dea     Month	th Day	Year	3. Time of Death
	/Medi	al	Mary		. 6 1	Wilso	1		( D 1)	_3	23	06	MES: (1)
	Examir	er	4a. Facility Name (If not institution Genesis Mult:					n, or Location	or Death			y of Death	
	Funeral		5. Social Security Number			. last birthday)	If Under 1 Ye			8. Date of Birth	)	9. Birth	re place (State or Foreign intry)
L	Director		218-24-3912	1□M <b>2</b> □F	80	Yrs.	Months Day	ys Hours	Min.	(Month, Day 6-24-2	, Year) 25	Соц	Mā.
	pu *		Usual Residence of Decedent  10a. State 10b. County		100 0	10c. City, Town or Location						404 1	
	fanyla sho	ō	Md.	NA	100. 0	,,	Ltimore						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number				10f. Zip Code	9			0g. Citizen of	What Cou	21
	3 with		1633 Carswell	Street			212]					Wilat Cou	intry :
	death	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.			gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Expriser mast be notified at	/Fu	1 XNever Married 2 ☐ Marr	ed 1 ☐ Yes	2 No	1	1 ⊡Yes 2 😾 N		i, Puerio	Hican, etc.)		ck, White,	
21215-0036	hours ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:						Speci		lack
5	n 72 n mat	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usual Oct kind of work do DO NOT use ret	ne durina mos	t of worki	ng	16b. Kind of E	Business/Ir	ndustry
7	withi	duo	Elementary/Secondary (0-12)  11th grade	College (1-	4or 5+)		esser	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Lord B	alt∵in	nore Laundry
ğ	il Hygie other	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle, i			note haundry
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event interment by notified at ance.	To B	James	Per	су	Gibs	son	F1	oren	ce		Wi	ilson
an	2 sho and I is me	·	19a. Informant's Name/Relationsi							l Route Number	•		p Code)
	and lealth m 27 her tr		Shanika Lewis	Ni	ece					Baltimo			1218
0	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 □ Burial 2 및 Cremation	3 □Removal from S	tate	cemetery, crer	sition (Name of natory or other p	olace)			20c. Location		
Itimore,	it. Pa rtmen rtant: njury		' 4 ☐ Donation '5 ☐ Other (Si		Gi	_	int Cem.		3–29-		Baltim		
Ba	permit. Departr Imports any inju		21. Signature of Furieral Services	71/2 Ht	21		! Name and Ado larch F.		•		imore, E. Nor		21202
8760,	Physician / Medical Examiner prize sician and prize l'Itansit pri l'Itansit prize l'Itansit prize l'Itansit pr	al Examiner	shock, or heart failure. List mnediate Cause (Final rd sase or condition sulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c		quence of):	MIMI	INF	ALC	TILLN			Interval Between Onset and Death
.O. Box 6	the death certiticate by the attending phys ached tor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2∏Feta nt at time of o	al death 3	Ectopic pregnal				1.4	ate of deliver	ery Day Year
rds, P	luires that n signed b	þ	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the ur	nderlying cause	given in Part I.		23e. Did tob		-	he cause of death?
al Records,		Completed									sy prior to completion of cause of		
Vital	s certitio	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital:	patient 2	ER/Outpatien	t 3 DOA			Check onlon		or Count	
Division of	To the Hospital or Attending Physician: within 24 hours after deals after deals To the Funeral Director: After this certilic completely tilled in by the funeral director,	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of (Month		28b. Time of Injury	28c. In		2	28d. Describe ho			y)
DIVIS	al or Attences after death	Certification:	3 Suicide 6 Could n 4 Homicide determi	200. Place	of Injury - At h g, etc. <i>(Specii</i>	ome, farm, stre fy)	eet, factory, offic	e	2	28f. Location (St. City or Town	reet and Numb I, State)	oer or Rura	al Route Number,
	To the Hospital or within 24 hours atter to the Funeral Discompletely tilled in	edicai (	29a. Certifier 1 ☐ Certifyin (Check only one) 2 ☐ Medical E	Physician: To the lack and manners	sis of examina	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and y opinion, deat	d place, a	and due to the ca	use(s) and mate and place,	anner as s and due to	tated. the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier				29c. Lice	nse number		25	9d. Date signe	d (Month,	Day, Year)
			115	MO			1	4791	15	V	MARC	1428	, 2006
			30. Name and address of person v	who completed cause	of death (Iter	m 23a) (Турв, I	Print)				, , -		1
			31. Date filed (Month, Day, Year)	Em m	0)1	05 0	3000	PAIV	= 10	) Wigh	mp	212	04
	Sta Registr	- 4	MAR 3 0	2006	Sistrar s Signa	S. Apr	ME			) WIGH			

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

s after dec. filled in by

Medical

29b. Signature and title of certifier 40 cloupmoight

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimore MD 21215 BRAHIM Elov Andi atti 2434 West Ischrober C ANG

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

32. Registrar's Signature

MAR 3 0 2006



within 24 hours a

completely

b

Registrar

			1 - For State Registrar	State of M		epartmen Certificat		ealth and M Death		iene	6 (	9829
	Physic /Medi		1. Decedent's Name (First, Middle, L MA Hhew Wi)	asi) I I AMS			· ·		2. Date of Deat Month MARCH	h Day	Year 2006	3. Time of Death
	Examin			2 Enter	) ge (In yrs. last birti	Ba/a	hmene 1 Year	ocation of Death	8. Date of Birth	4c. County	vk	lace (State or Foreign
1	Director		237 /2 0892 Usual Residence of Decedent	1 <b>№</b> M 2□F	90	rs. Months	Days	Hours Min.	(Month, Day, March 2	Year)	Coun	V.C
	with the Marylan a or 28a-1 ehow be notilled at	ctor	10a. State 10b. County  MD N/a		BAILIN						1	0d. Inside City Limits 1 → Yes 2 □ No
	ith with th	Funeral Director	10e. Street and Number	st		10f. Zip	Code 213		11	og. Citizen of		try?
960	Reme	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces	? _	13. Was Deced If Yes, spec		panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Rac	ce - Americ ck, White,	
0.45.0	ithin 72 hc ie. ien "netur Medical	Completed	15. Decedent's (Specify only highest g			Decedent's Usua (Give kind of wor life. DO NOT us	k done du e retired)	ring most of working	g	16b. Kind of B		lustry
Mondond 0101E-000E	d 2 should be filed within and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be Con	17. Father's Name (First, Middle, Las	<i>(</i> 1)		onstructi	1	8. Mother's Name		CUNSTRU Maiden Suman		
Z CM	s 1 and 2 should if Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship  AliCE Powe!  20a. Method of Pisposition	(Type, Print)	180	22 8.	(Street an	od Number or Rural	timus M	71213	-	
Poltimore	permit. Pages Department of I Importent: if ite any injury or of page.		1 ☑ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ify)	' I	Disposition (Name, crematory or of				20c. Location		wn, State
<u>a</u>	perm Depa impo		21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or co	Buto		1129 N.	CArol,	ne 54 B2	Itamore M	15 ON		
8760 0		dical Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence o	my sy str	00	ardin y di	( ch-	avei	tein	Approximate Interval Between Ons, it and Death
23, 2006.	attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe					te of deliver	ry Day Year
CHAN 03, 23		Completed by Ph	Part II. Other significant conditions Chronic 05	contributing to death b	out not resulting in	the underlying ca	use given	in Part I.	23e. Did tob			e cause of death? ably 4 □Unknown
(AR)	The la ete has paga 2		17 per sura	err C	YEA DE	7.			24a. Was an autopsy perform 1 ☐ Yes 2	ed?	Were autop prior to com death? I ☐ Yes	sy findings available inpletion of cause of 2 No
LIARS TREAM	ding Phys th. After this funeral di	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigate 2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Inj	iry 28b. Ti y Year) Inj	me of 28 ury M	Other:  Bc. Injury a Work?  1 □ Ye	t 20		nce 6 Oth w injury occurr	ed	
)/77/C	ospital or pours after uneral Dire	al Certl	29a. Certifier 1 Certifying P	building, et	of my knowledge.	death occurred a	it the time	date and place, ar	City or Town,	State)	nner as sta	tted.
9	To the Ho within 24 F To the Fu completely	Medical	(Check only 2 Madical Example)  29b. Signature and title of dertifier	minar: On the basis o	t examination and	or investigation,	License n	ion, death occurred	d at the time, da	te and place, and de de de de de de de de de de de de de	and due to	the cause(s)  Day, Year)
	1		30. Name and address of person why	cor pleted cause	. ~ ~	ype, Print)	A	16.0	CX	MAN	ch 2	3, 2006
	Sta Registr		34. Date filed (Month, Day, Year) MAR 3 0 2	32 Registr	ar's Signature	Couls	1 4 .	coco	- 0/. (		0.01	4 600

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of State of Maryland / Department of Certificate of Certific		ental Hygie Reg.	O 10 10 10	00000						
	-	Decedent's Name (First, Middle, Last)		2. Date of Death	(	3. Time of Death						
Physic /Medi	cal	CATHERINE M. WILEY  4a. Facility Name (If not institution, give street and number)  4b. City, Town	M , or Location of Death	ARCH 29	Day Year 2006 4c. County of Death	12:14 pM						
Exami	ner		rimore		N/A	'.						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs. 8	B. Date of Birth	9. Birth	place (State or Foreign						
Director		220-18-4640 1 M 2 N F 80 Yrs. Months Dat	rs Hours Min.	EB. 18	71926 MAI	RYLAND						
pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
shov	5					XXYes 2 □ No						
the M	Director	MD N/A BALTIMORE  10e. Street and Number 10f. Zip Cod		100	Citizen of What Cou							
with Ba or	2		21224	109.	U.S.A.	y.						
death ms 23	Funeral		of Hispanic Origin? (Speci uban, Mexican, Puerto Ri	ify Yes or No-	14. Race - Amer							
within 72 hours after death with the Maryland ane. than "natural," or items 23a or 28a-f show the Madical Examination the modical examination.	/ Fur	1 Never Married 2 Married 1 Yes 2 No		ican, etc.)	Black, White							
72 hours natural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			W fi	ITE						
n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work do life. DO NOT use re:	ne durina most of working	7   166	o. Kind of Business/Ir	ndustry						
	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 ADMINIST		υ.	S. MARS	HAL'S						
be filed within 72 ho tal Hygiene. d other than "natui event, I'm Mudled	a	17. Father's Name (First, Middle, Last)	18. Mother's Name (									
and Mental Hygi smarked other sumatic event, I	To B	HOWARD WILEY	CUNIGU	NDA ZO	ORN							
2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	eet and Number or Rural I	Route Number, Ci	ity or Town, State, Zi	ip Code)						
1 and Health em 27 ither tra		KATHLEEN YEAGER/ NIECE 2925 NEW Y			•							
of Heal		20a. Method of Disposition  X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other)	place) Dat	te 200	. Location - City or T	Town, State						
Pages ment of lant: If it		`4 □Donation 5 □Other (Specify) SACRED HEART										
perriit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic Oncs.	1	21. Signature of Funeral Service Licensee  22. Name and Ad LILLY & 700 S.	TEILER IN CONKLING S	C. FUNE	ERAL HOM	E E.MD. 21						
4		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.				Approximate Interval Between						
Physician		Onset and Death										
/Medical Examiner		disease or condition resulting in death)  a. Chronic observative framework duelace  Due to (or as a consequence of):										
Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate  b. Utche te Moll. du  Due to (or as a consequence of):			<del></del>							
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury										
be executed sician and burial-transit	Exai	that initiated events c. Due to (of as a consequence of):	Due to (of as a consequence of):									
icate be executed physician and s the burial-transit	edicai	Co Osteo percera,										
	fedi	V										
law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physiclan/Mo	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	ncv		23d. Date of deliv	,						
e dea the at ned fo	Sicl	in the past 12 months?  1 ☐ Yes 2 Mo 9 ☐ Unknown  1 ☐ Unknown			Month	Day Year						
res that the de signed by the s be detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	gwon in Part I	23e Did tobac	co use contribute to	the cause of death?						
ires ti signe d be c	i by	Take the distance of the contributing to death out not resulting in the distance plants.	given in rasti.	1 ☐ Yes	/							
w requir been si should	Completed			24a. Was an								
The law ate has page 2 s	I di			autopsy performed	prior to c	topsy findings availab ompletion of cause of						
	e Co	OF Was ages relevant to marked		1 ☐ Yes 2 🗷		2□ No						
sicial certi irecto	00	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	26. Place of Death / Other:		e 6 Other (Spec	25.1						
Attending Physician: The r death. ector: After this certificate his by the funeral director, page	n; To			Bd. Describe how		ary)						
ttending F death. ctor: After y the funer	atto		Vork? ☐Yes 2☐No									
r Atte er de: recto by th	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce 28	3f. Location (Stree City or Town, S	et and Number or Rui	ral Route Number,						
ital or rs afte al Dir		gallarity, etc. (epochy)	ļ									
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.										
To the within 2 To the complet	Me		ense number	29d.	Date signed (Month	n, Day, Year)						
F > F 0		SERASTIAN JOHN DO	0055171		3/29/04							
10		30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print)										
Įυ		3023 Eastern Avenue Boltima	e Mo	2122	4							
	ate	31. Date filed (Month, Day, Year) 32. Degistrar's Signature										
Regist	rar	MAR 3 0 2006										

	P-0-11-0-0		1 - For State Registrar	State of M	laryland / Dep	oartme		Ith and	-			09831	
2	Physic /Medi	cal	Decedent's Name (First, Middle, L     Oliver Ico     4a. Facility Name (If not institution, gi	Ann	-)	4h C	ity, Town, or Loc	eation of Deat		Day 14, 20		4:20 p M	
	Examinum - Funeral Director	ier	1419 East-West Hig	nway Sex 7. A	ge (In yrs. last birthda 89 Yrs.	₩e	st Hyatts			Pr	ince Geo		
	D D	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		10c. City, Town or West. Hyat		le		TOVALISO			10d. Inside City Limits 1 ☐ Yes 2 No	
	th with the 23s or 28s	ai Director	10e. Street and Number 1419 East-West Highw				Zip Cod <i>e</i> 20 <b>7</b> 83			10g. Cit	izen of What	t Country?	
9800	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examinar must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? No	_	cedent of Hispa pecify Cuban, N 2X No Si		pecify Yes or No Rican, etc.)	0-	14. Race - A Black, V SpecifyWh:	Am <i>e</i> rican Indian, Vhite, etc. ite	
21215-0036	d within plene. r than "	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade <i>completed)</i> Coflege (1-4or 5+	5+) (Giv	e kind of	sual Occupation work done durin ruse retired)	g most of wor	rking	16b. K	ind of Busine	ess/Industry	
Maryland	2 should be filed and Mental Hygi is marked other aumatic svent, I	To Be (	17. Father's Name (First, Middle, Las August Heinrich Ap 19a. Informant's Name/Relationship	p	19b. Ma	iling Addr	Kat	harina (	Obermaier	rst, Middle, Maiden Surname) maier ute Number, City or Town, State, Zip Code)			
di.	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic once.		Michael A. App/ Social Social Social App/ Social Social Social App/ Social Social Application Social Applica	☐Removal from State	1330 20b. Place of Dis	Crock position (from the material of the control of	ett Lane, Name of or other place)	Silver	Spring, l	MD 209	004 ecation - City	or Town, State	
Balt	permit. Departr Importe eny inju		21. Signature o Funeral Service Lice	Cole		500 U	niversi	ty Blv		ilve	me Inc r Spri	ng, MD 20901	
8/60,	Physician //Medical Examiner	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Societies of the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Maligna Due to (or as Chronic b. Due to (or as	d the death. Do not eine.  Int Neoplas a consequence of): Cobstructi a consequence of): a consequence of): a consequence of):	sm of	Lung		c or respiratory a	arrest,		Approximate Interval Batween Onset and Death	
. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetaf death 3	□Ectopic	pregnancy (specify)		-		23d. Date of Month	delivery Day Year	
ords, P	Physician: The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached	by	Part II. Other significant conditions Hypertensive Car			underlyin	g cause given in	Part I.				e to the cause of death? ] Probably 4 □Unknown	
Ital Kecord	an: The law tificate has b tor, page 2 s	Be Completed	25. Was case referred to medical	200			26	Place of Dea	24a. Was auto perfet 1 Yes	psy ormed? 2 <b>X</b> No	prior	a autopsy findings available to completion of cause of n? Yes 2 No	
DIVISION OF VITAL	Attending or death.	Certification: To E	27. Manner of Death 1 🖺 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				DOA Other: 4 28c. Injury at Work? 1 □ Yes	☐ Nursing H	ome 5 Resi	how injur	y occurred	Specify)  Rural Route Number,	
2	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical Cer	(Check only 2 Medical Exa	nysician: To the best	tc. (Specify) of my knowledge, deal of examination and/or i	ath occurre	ed at the time, do	ate and place	, and due to the	cause(s)	and manner	r as stated. due to the cause(s)	
	To the within 2	Med	29b. Signature and title of certifier  29b. Add Add Add Add Add Add Add Add Add Ad	and manner st	ated.	2	9c. License nur D263	nber		29d. Dat	e signed (Mo	onth, Day, Year)	
	Sta Registr		Martha A. Schnei 31. Date filed (Month, Day, Year)	der, M.D.	5401 MacAF			NW, Wa	shingto	n, Do	2001	6	

				partment of Health and ertificate of Death	Mental Hygier	2000 0000					
I	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> John Glenn Beall		2. Date of Death Month March 24	3. Time of Death					
5	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h 4	4c. County of Death					
			44 Beall's Lane  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Frostburg  If Under 1 Year   If Under 24 Hrs		Allegany  9. Birthplace (State or Foreign					
da.	Funeral Director		216-22-7424 1X M 2 F 78 Yrs.	Months Days Hours Min		1927 Cumberland					
	rland ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits					
	Ba-1 sh	ctor	MD Allegany Frostb	urg		1 ☐ Yes 2 ☐ No					
	h with th	al Dire	10e. Street and Number 44 Beall's Lane	10f. Zip Code 21532		Ditizen of What Country? USA					
336	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or items 23e or 28e-1 show imatic event, it a Mudical Examinat instraal be rigitlied at	by Funeral Director	1 □ Never Married 2 □ Married  3 □ Wirtnwed 4 □ Diverged  1 □ Wirtnwed 4 □ Diverged	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036	within 72 horane. Than "nature"	Completed	(Specify only highest grade completed) (G. Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)  Broker	rking	Kind of Business/Industry					
Maryland 2	be filed tal Hygird of other event, I	To Be Co	12 4  17. Father's Name (First, Middle, Last)  J. Glenn Beall	18. Mother's Nat	me (First, Middle, Maide						
Mary	0 m m	-		ailing Address (Street and Number or Ru Beall's Lane, E							
a)	s 1 and if Health Item 27 other to		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)		Location - City or Town, State					
altimore,	Pages Iment of Iant: If It			rg Mem Park Mar							
Ball	permit. Pages Department of Important: If It ery injury or o		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Ha 58 Frost Ave.,	Frostburg						
	Physician		23a. Part1. Enter the disease, or complications that coursed the death. Do not a show or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Metas TATIC	enter the mode of dying, such as cardian		Approximate Interval Between Onset and Death					
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			7-31					
j	nsit	miner									
8/60, •	cate be executed physicien and the burial-transit	dical Examin	that initiated events resulting in death) Last  Due to (or as a consequence of):								
9		Medic	IF FEMALE:								
O. Box	at the death certifi by the attending r tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	B Ectopic pregnancy C Other (specify)		23d. Date of delivery Month Day Year					
1	law requires that the as been signed by th 2 should be detache	P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown					
II Kecords,	The ate h page	Completed	PROTTEN CALORIE MALNUTRITION	2° 70 MALABSUR	24a. Was an autopsy performed?						
or Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other	ath (Check only one)						
lon of	To the Hospital or Attending Physicis within 24 hours after death. Within 24 hours after death within this cert to the Funeral Director. After this cert completely filled in by the funeral direct completely filled in by the funeral direct	ation; To	27. Manner of Death  1 Shatural 5 Pending 2 Accident Investigation  1 Inpatient 2 ER/Outpat  28b. Time (Month, Day Year)  28b. Time (north, Day Year)	of 28c. Injury at	lome 5 Residence 28d. Describe how in						
DIVISION	ital or Atterns after de ral Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)					
	Hosp 124 hou Fune letely fil	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	a, and due to the cause arred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)					
	To th Withir To th	Me	29b. Signature and title of certifier	29c. License number	Α.	Date signed (Month, Day, Year)					
	0	-	30. Napra and address of part of who completed cause of death (Item 23a) (Type	D4205 4	ma	nch 24, 2006					
	U		pr. Gregg C. Donaldson, 912 S		rland, MD	21502					
	Sta Registr		31. Date filed (Month, Day, Year)  22. Registrar's Signature	role							

			1 - State Registrar	,	artment of Health rtificate of Death	ו	Reg.	2000	09833					
39%	Physici		Decedent's Name (First, Middle, Last)     CHARLES THOMAS BREEN			Mon		Day Year	3. Time of Death 6:00 p M					
12	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		.CII 11	, 2006 4c. County of Death	0:00 p					
			Prince George's Hospital	L	Cheverly			Prince Ge	eorge's					
	Funeral Director		5. Social Security Number 217-32-2282  Usual Residence of Decedent	(In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under Months Days Hours	r 24 Hrs. 8. Date Min. (Mor Apr	of Birth oth, Day, Ye il 14	9. Birthplace (State or Foreign Country) 14, 1937 Pennsylvania						
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits					
	Ba-f s	Director	Florida Seminole	Winter	Park				1X Yes 2 No					
	ith th 0, 2,	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coun	itry?					
	e 23e		2355 Sorrento Circle		32792			U.S.A.						
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Iteme 23a or 28a-f show event, the Medical Evertical must be colified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  1 □ Yes 2 ☑ N  If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 ☐ Yes 2 <mark>反</mark> No <i>Specify</i> :		or No- tc.)	14 Race - Americ Black, White, of Specify: Whi	etc.					
ğ	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b	. Kind of Business/Ind						
21215-0036	l within 7 liene. r then "n I're Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	+) life.	kind of work done during mos DO NOT use retired) Management Mar			George Was	hington					
פנ		BeC	17. Father's Name (First, Middle, Last)	, Data		er's Name (First, A	diddle, Maid		itty					
<u>Jai</u>		10	Charles C. Breen			Marie Mc	Closk	ey						
Maryland			19a. Informant's Name/Relationship (Type, Print) Beverly Breen - Wife		ng Address <i>(Street and Numb</i> Sorrento Circ									
	1 an Heal em 2 ther		20a. Method of Disposition			Date		Location - City or To						
ē			1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place)			rentwood,						
Baltimore,	permit. Page Department Important: if any injury or once.		21. Signature of Funeral Service Licensee		. Name and Address of Facili									
n	89 E 8		colutte May		739 Baltimore			sville, Ma	ryland 2078					
			23aPan 1. Enter the disease, or complications that wised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  a											
>	Pnysician /Medical		disease or condition resulting in death)	E MET+	ISTATIC B	RAIN DI	ESE	ASE L	Onset and Death					
	Examiner		2 10 1	consequence of):	LEANTE,	0 0 =	100		7. month					
	D #	ner	709											
	and I-trans	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consequence of):										
68/60,	rificate be executed ig physician and as the burial-transit	aiE	500.000.000	consequence on,										
200	tificate ng phy as the	ledicai	0.											
C. BOX	The law requires that the death cer te has been signed by the attendin bage 2 should be detached for use	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year						
as, r	quires that n signed b	by P	Part II. Other significant conditions contributing to death bu	t not resulting in the ur	nderlying cause given in Part I	l. 23e.	Did tobacc	co use contribute to the						
Vital Records,	has has	ompieted					Was an autopsy performad'	prior to con	osy findings available inpletion of cause of					
E E	(0 CT	Sec.	25. Was case referred to medical examiner?	TO THE RESIDENCE OF THE PARTY O	26. Place	e of Death   Check		No 1 Yes	2L No					
> 5	Phyeician: this certific ral director,	2	1 ☐ Yes 2 DeNo Hospital:	t 2 ER/Outpatien		ursing Home 5	Residence	6 Other (Specify	)					
	ding Phyen. h. After this intuneral direction	Certification:	27. Manner o Death 1 ☐ Natural 5 ☐ Pending (Month, Day)	Year) 28b. Time of Injury	28c. Injury at Work?	į.	cribe how in	njury occurred						
DIVISION	deat deat ctor: y the	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injured	y - At home, farm, stre			tion (Street	and Number or Rural	Route Number					
5	s afte	Cert	4 Homicide determined building, etc.	(Specify)	,	City	or Town, St	ate)						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best or and manner state	examination and/or inv	occurred at the time, date an restigation, in my opinion, dea	nd place, and due t ath occurred at the	o the cause time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)					
	To t Vithi comp	Ž	29b. Signature, and title of certifier	V.D	29c. License number	3		Date signed (Month, D	Day, Year)					
	B		CHEUN 1900	- /	A2188			3/12/06						
	31		30. Name an address of person who completed cause of de	ath (Item 23a) (Type,	is Rd, Suite#	215 /A	۸ (در،	M. 4	0 ==/					
	Sta	е	HEMA PYADLA MD 9476 31. Date filed (Month, Day, Year) 32. Redietral	's Supplied	is Ka, Sullet	313 6A	NHH	W.W.D	20106					
	Registra	ar	MAR 1 6 2006	you										

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland /		artment of H		Mental Hy	giene	ans.	09834
	Physici /Medi		Decedent's Name (First, Middle, La     PAULA	B. BROWN				2. Date of De Month MARCH	13 <sup>Day</sup>		3. Time of Death 9:35 P M
***	Examir	ner	4a. Facility Name (If not institution, git PRINCE GEORGE'S	HOSPITAL	L:46-4-1	4b. City, Town, or CHEVE			PF	County of Death	CORGE'S
	<ul> <li>Funeral</li> <li>Director</li> </ul>			Sex 7. Age (In yrs. last I	Vrs.	Months Days	Hours M	in. (Month, Da	th ay, Year) 24 19		nplace (State or Foreign untry) SHINGTON, DC
	a-f ehow	ctor	10a. State 10b. County  MD PRINCE	GEORGE S SPE	own or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
	th with the 23a or 28 lat be no	Funeral Director	10e. Street and Number 3508 EDWARDS ST	REET		10f. Zip Code 20774			-	S.A.	untry?
980	a within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-1 show the Modical Examinar roust be notified at	by	11. Marital Status  1 ☑Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	-	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2⁄2 No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK		e, etc.
Maryland 21215-0036	be filed within tal Hygiene. Ind other than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired AY CARE	during most of w	vorking		nd of Business/l	ndustry
yland		To Be (	17. Father's Name (First, Middle, Las PAUL BROWN	·)				lame (First, Middle	, Maiden	Sumame)	
	nd 2 lith a 27 ly r tra		19a. Informant's Name/Relationship KATHLEEN BROWN/	SISTER 8	324 N	ng Address (Street a	and Number or AD LAND	Rural Route Numb	er, City o	7 Town, State, Z 20785	
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State ceme.	tery, crer	esition (Name of matory or other place CEMETERY	-	Date L8/2006		cation - City or T	
Balt	permit. Page Department of Important: If eny injury or		21. Signatura of Hungral Service Lice	nsee	1	2. Name and Addres		J. B. JE AD LANDOV			
**	Physician /Medical Examiner	1	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	b. Due to (or as a consequence)  Due to (or as a consequence)	- A				rrest,		Approximate Interval Between Onset and Death
,0928	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Survey Due to (or as a consequence d.	nte	estrud	MAC	Them.	nej	hape	iday
P.O. Box 6	the death certific by the ettending places as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Into 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
	w requires that the de been signed by the e should be detached f	Completed by P	Part II. Other significant conditions  Penfuncted  ENTERS C  M. trail Value	Gastric Vice	576		en in Part I.		Yes 2[	□No 3□Pro	the cause of death?  bbably 4 Dinknown  topsy findings available
al Re		е Сотр	Respirator  25. Was case referred to medical			+NEMIA		auto perfo	psy ormed? 2 No	prior to death?	ompletion of cause of
Division of Vital Records,	this al di	To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	n (Month, Day Year)	Outpatien Time of Injury	28c. Injury Work	er: 4 🗌 Nursing	Home 5 Resi	dence 6		rify)
Divis	tal or Attend is after death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not to determined		farm, str	eet, factory, office		28f. Location ( City or To			ral Roufe Number,
	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	edicai	one)	hysician: To the best of my knowled miner: On the basis of examination a and manner stated.	ge, death and/or in	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To To DE	M	29b. Signature and title of certifier	le volino		.29c. License		2	29d. Date	e signed (Month	, Day, Year) 4 2006
4	A 5		30. Name and address of person who	completed cause of death (Item 23a	1) (Type,	Pueers	bung.	Rd My.	475	wille	42006 4020789
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2006	32. Registrar's Sonature	have						

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U	d	0	U	0

			1 - For State Registrar Amend Item  1. Decedent's Name (First, Middle, La.)	n #9 Per F	H G853 396	voificetempf	Death		Reg. No.	UU	3. Time of Death
	Physici		Louise	Bunting				Month	Day 16	2006	7:15 A M
1	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death			ty of Death	7.13 A
	X		Atlantic Genera	l Hospital		Berli	n		Word	cester	
	Funeral Director		230-22-3362	- 1/14	e (In yrs. last birthday 12 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 9-6-19	y. Year) 13		place (State or Foreign htry) h Carolina
	and wo		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	IOd. Inside City Limits
	death with the Maryland ims 23e or 28e-f ehow if must be notified at	Ę	MD Worces	ter	Ocean C	i + x7					1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number		occan o	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	th wit		10211 Bent Creek	Rd.		218	42		USA		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-1 ehow amy follower: If item 27 is marked other then "natural; or other traumatic event, its Medical Examinar must be positived at DDCs.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 2 4 If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)	14. R B	ace - Americ lack, White, cify: Wh	
0-017	filed within 72 hours after Hygiene. sthar than "natural, or ite ont, ire Medical Exertine	Completed	15. Decedent's Education (Specify only highest grant Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of world)	king	16b. Kind of	Business/In	dustry
V	ygien ygien f,	S	12		0	wner/Oper				staura	int
	be fill bd ott	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sum.	ame)	
Ž	hould d Mei mark	2	Mitchel Golden  19a. Informant's Name/Relationship (	Tyne Print)	19b Mai	ing Address (Street		Lupton	er City or Tow	m State Zir	Code)
Z Z	uth an		Jayne Bunting	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		l Marlowe					0000)
ນັ	s 1 ar		20a. Method of Disposition		20b. Place of Disp	osition (Name of omatory or other place	cal	Date	20c. Location		own, State
	Pages nent of int: If it		1 ☐Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)		1	emorial P	I	/2006	Berl	lin, M	ID
Dal	permit. Pag Department Importent: eny injury o		21. Signature Fune a Service Licer	soo usbalc		22. Name and Addre	am St.	e Burba	ge Fune	eral H	
	Physician /Medical Examiner		23a: Part1. Enter the disease or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence of):	Suga	ousm	~		1/5	Approximate Interval Between Onset and Death
,00700	rificate be executed ng physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Ante	a consequence of):	norc norc	Coron		BUS "	Bisc	ns
	Attending Physician: The law requires that the death certifics rideath.  r death.  ector: After this certificate hes been signed by the attending ply the funeral director, page 2 should be detached for use as to be the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death 3	□Ectopic pregnanc	у			Date of deliver	ery Day Year
cords, T	uires that signed by Id be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.		obacco use co		he cause of death?
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5	hysica his ce	To B	examiner? 1 Yes 2 X No	Hospital: 1 🔀 Inpatie	rit 2 ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	dence 6 🗆 C	ther (Specif	y)
	ath. ath. r: After ti	ertification:	27. Manner of Death 1 🖾 Natural 5 🗌 Pending 2 🗍 Accident investigation		y Year) 28b. Time Injury	Wor	yat nk? Yes 2 □ No	28d. Describe h	now injury occ	urred	
22	al or Attendi s after death. si Director: A ed in by the fu	Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Nur vn. State)	nber or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerei Director: A completely filled in by the fu	Medical	29a. Certifier 1 🗡 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examination and/or i	th occurred at the til nvestigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time,	cause(s) and i date and place	manner as s	tated. o the cause(s)
	Withi To the	ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
			lee	eee		D4625	57		3-16-2	006	
J	15		30. Name and address of person who Edwin Ca	completed cause of d staneda, M		Print) 01d Ocea	an City B	lvd., Be	erlin,	Md. 2	1811
17	Sta		31. Date filed (Month, Day, Year)		ar's Signature						

DHMH 17 Rev 1/2001

State Registrar

MAR 1 7 2006

# **Physician** /Medical Examiner **Funeral** Director r then "natural", or Iteme 23a or 28a-f ehov the Medical Examinar must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Daniel Brittingham 9:35PM 15,2006 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804 WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 10XM 20 F 222-16-1010 June 1. 1928 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo **Funeral Director** Whaleyville MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11647 Sheppard Crossing Rd. 21872 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 卷☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes X ☐ No Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auctioneer Auction House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Brittingham Annie Ellen Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darlene Ennis (Daughter) 11647 Sheppard Crossing Rd., Whaleyville, Md. 21872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX urial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dale Cemetery 3-18-2006 Whaleyville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulling in death) Due to (or as a popequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 28 No Be 25. Was case referred to medicat 26. Place of Death Check only one examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Mursing Home 5 Residence 6 Other (Specify) Certification: To 3∏ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Waturai 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Physician /Medical Examiner

marked other other treumatic event,

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Department of Health a Important: If item 27 le eny injury or other tre gace.

t and 2 should be Health and Mental

Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Division of Vital Records, P.O. Box 68760, certificate has been signed by the a rector, page 2 should be detached f this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the

31. Date filed (Month, Day, Year) State Registrar

WILLIAM ROBINS, M.D. MAR 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Jeffrey A. Brice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-Q1707 NJM State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** ttrey Hlexander 9 2006 0838 March /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Easton Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Houte Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 100M 2□F Yrs. 215-53-472. Usual Residence of Decedent Director May 30, 1962 Marylano Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. I other then "neturel", or Items 23a or 28a-1 ehow event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Talbot aston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Stree 109 2 160 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Industr Seafood rabbing 12 ith and Mental Hygie 27 is marked other r traumatic event, III 17. Father's Name (First, Middle, Last) 46. Mother's Name (First, Middle, Maiden Sumame) Be Bertha Cora Mae ဥ Franklin Eugene BruMMe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route\_Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 ie any Injury or other trau once. 244 Candle Light Ln. Glen Burnie, MD. 21061 hyllis ice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Royal Oak Cemetery 3/18/06 Royal Oak, Mary land 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility
HENRY FUNERAL HOME, P.A.
510 Washington St. Cambridge, 21. Signature of Funeral Service Licensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Gashaintestinal hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No Chronic alcohousm 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑Yes 2 □ No 24a. Was an autopsy performed? 2□No Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) tx∑xYes 2 □ No Certification: To 2XXR/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death entificate be executed within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral (

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tarko MLD OCME March, 10, 2006 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

Tasha Z Greenberg Le1 '0

2006 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State Registrar

			1 - For Stete Registrer	State of	Marylar				ealth a		ntal Hygi	ene g. No.	5 (	983	8
	Physicial		1. Decedent's Name (First, Middle	, Last)						-	. Date of Death Month	Day_	Year	3. Time of	Death
<u>\$</u>	Physici /Medic			Evelene		ş				M	neel	25	2006	10:39	AM
100	Examin	er	4a. Facility Name (If not institution	, give street and num	nber)		4b. City,	Town, or	Location	of Death			nty of Death		
		/580.	Coffman Nursin		7 Ann /In	la a a b inda nla )		gerst	town If Under	24 Hrs o	. Date of Birth	W	ashin		
00A	Funeral Director		214-34-9949	1 □ M <b>2</b> C F	7. Age (In yrs. <b>81</b>	Yrs.	Months	Days	Hours	Min.	(Month, Day,			place (State or ntry)	r Foreign
	4		Usual Residence of Decedent							LVI.	ay 11,1	924	Mar	yland	
	ylanc how		10a. State 10b. County		10c. Ci	ty, Town or Lo								10d. Inside Cit	•
	e Ma	ctor	Md. Wash	nington		Ş	Smith	sbur	3					1 <b>X</b> Yes	2 🗌 No
	or 28	Oire	10e. Street and Number				10f. Zip	Code			10	g. Citizen o	of What Cou	ntry?	
	ath w	ra I	4 Blue Mt. Est						2178					S.A	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  In Marked Other than "natural", or Iteme 23a or 28a-f show asmalic event, it is Marked Examirat must be in illied at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 🏋 Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	сөs? 2 <mark>Ж</mark> No ө		Was Dece If Yes, spe 1 ☐ Yes		ispanic Ori n, Mexicar Specify:		ly Yes or No- can, etc.)		lace - Ameri llack, White, c <i>ify:</i>		
9	tura stura	ed	15. Decedent			16a. Dece	dent's Usu	al Occupa	ation		1	6b. Kind of	Business/In	dustry	
Maryland 21215-0036	within 72 iene. than "na	Completed	(Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give life.	kind of wo DO NOT u	ork done d se retired Aid	<i>luring</i> mos )	st of working			oup Ho	,	
0	I Hygie other	BeC	17. Father's Name (First, Middle,	Last)		·			18. Mothe	er's Name (F	First, Middle, M	aiden Sum	a <i>m</i> e)		
a	Ald be hental riked o	To B	John Law						Ro	sa Ki	ndle				
ary	should and Men s marke		19a. Informant's Name/Relations	niø (Type, Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rural F	Route Number,	City or Tow	m, State, Zij	Code)	
	and 2 Balth a m 27 ls		Robert E. Collir	s (Son)		P.O.	Box	231 2	Zulli	nger,	Pa. 172	72			
Baltimore,	- T 6 =		20a. Method of Disposition? 1X Burial 2 □ Cremation	3 Removal from S	state	Place of Dispo cemetery, crer	natory or o	other place	B) (M	Dat larch		0c. Location	n - City or T	own, State	
Ē	Pages ment of I ant: If It		4 □Donation 5 □ Other (S)		Ri	nggold	Ceme	tery	1	2006	30,	Ring	gold,	Md.	
ä	permit. Departr Imports any Inju		21. Signature of Funeral Service	Licensee					s of Facilit	•				y Ave.	
=	<b>7</b> □ □ ≈ 0	_	23a. Part1. Enter the disease, or	e_DAU							ome Smi		rg,Md.	. 21783 Approximate	
1000年の第二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十二十	Pnysician /Medical Examiner	ıer	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a Due to (	Vruei	e pu	waf		7	ne ne			7	Interval Betwonset and D	veen
<b>68760</b> , \	ificate be executed g physician and as the burial-transit	edicai Examiner	that initiated events resulting in death) Last	c. Due to (d	or as a consec	nce of):	rein	y d	Me	ne			Z	5 Jea	<i>\</i>
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۳.	res that tigned by	y Ph	Part II. Other argnificant condition	ns contributing to de	ath but not res	sulting in the u	nderlying o	ause give	n in Part I	l.	23e. Did toba	acco use co	ontribute to t	he cause of de	eath?
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>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2	ER/Outpatier	nt 3 🗆 D0	Othe	· ·		5 ☐ Resider		ther (Speci	6v)	
ō	Phy er the		27. Manner of Death	28a. Date o	f Injury	28b. Time of		28c. Injury Work			d. Describe how			7/	
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Division of Vital Records,	al or Attending P s after death. sl Director: After i	Certification:	3 Suicide 6 Could r 4 Homicide determ	28e. Place building	of Injury - At h ig, etc. (Speci	ome, farm, str fy)	eet, factor	y, office		286	Location (Str. City or Town,		mber or Run	al Route Numb	ber,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the tune	Medicai (	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	nd place, and ath occurred	d due to the ca at the time, da	use(s) and i te and place	manner as s e, and due t	tated. o the cause(s)	
	To t To t	Σ	29b. Signature, and title of certifier					c. License		-		_	ned (Month,	-	
			>ttmost Cu	on, MO	)			$\nu 3$	46.	55	n	mel	127	1006	•
	2		30 Name and address of person Samuel Chan	who completed cause M.J-32	of death (Ite	n 23a) (Type, Intie	Print) tam	St.	Ha	9013	toun,	MD	217	140	
Posterior	Sta Registr		31. Date filed (Month, Day, Year)	0 2006 32. 8	gistrar's Sign	atury /	CONC	9	_	/	,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** 22**,** HARRY ISA COHN February 2006 10:56 p<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/31/1941 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs 65 North Carolina Director 240-60-9624 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "netural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6920 Hanover Parkway, Apt. 201 20770 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status . Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene. tant: If item 27 Is marked other than "netural; or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Theatre Manager Theatre 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leo Cohn Vera Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Merritt O'Brien - Cousin 1033 Newburg Circle, Raleigh, NC 27603 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 N Removal from State injury or 4 □ Donation 5 □ Other (Specify) Willowdale 2/28/2006 Goldsboro, North Carolina permit.
Departr
Imports
any inju 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Shumate-Faulk Funeral Home & Crematory, Inc., P.O. Box 167, Goldsboro, NC 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician Metastatic Carcinoma of Lung 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 2**X** No the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ို 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: / 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours at e Funeral D letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier pletely and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D23181 March 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajkumar G. Bhojraj, MD 704 Gorman Avenue, #T1, Laurel, Maryland 20707 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

MAR 3 0 2006

	-	_ FOI		artment of Health and M rtificate of Death		giene Rag. No.201	16	0984
€		Decedent's Name (First, Middle, Last)			2. Date of Dea		W 474	3. Time of Death
Physicia		Irene Collins			Month 3	16 Day 200	Year )6	4:40 A M
/Medica Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County	of Death	L
Lxamme		509 Philadelphia Ave.		Ocean City		Word	este	r
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	h Vear	9. Birthpi Coun	lace (State or Foreign
Director		218-16-8725 1□M 2€F 82 Y	rs.	Months Days Hours Min.	5/30/	1923	Court	VA
P .		Usual Residence of Decedent						
aryla show	_	10a. State 10b. County 10c. City, Town					11	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
88-1	Director	MD Worcester Ocea	n (	<del></del>				
with the		10e. Street and Number		10f. Zip Code 21842		10g. Citizen of W USA	hat Coun	try?
hours after death with the Maryland urel', or Items 23s or 28s-f show at Examiner must be notilised at	Funeral	509 Philadelphia Ave.  11 Marital Status 12. Was Decedent Ever in U.S.	10.1		anit. Van an Na		Amoria	an Indian,
ltem nerr	Ä	11. Marital Status  1 □ Never Married 2 ▼ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2√ No	13.	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		k, White,	
I'. or	Š	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 🙀 No Specify:		Specify:	Whi	.te
CU DO UN		15. Decedent's Education 16a.	Dece	dent's Usual Occupation		16b. Kind of Bu	siness/Inc	dustry
nin 7.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done during most of work DO NOT use retired)	ring			
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be filed within 72 hours Hall Hygiene.  Ind other then "neture event, the Madical	Re C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle,	Maiden Sumame	в)	
uld b Ments rrked	0	John Jones		Ethe1	Brasure	2		
and l		19a. Informant's Name/Relationship (Type, Print)	Mailir	ng Address (Street and Number or Rur	al Route Numbe	er, City or Town, S	State, Zip	Code)
and 2 paith n 27 l				Philadelphia Ave.	Ocean			
of Herritan		20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State  20b. Place of cemetery	Dispo , crer	sition (Name of matory or other place)	Date	20c. Location - 0	City or To	wn, State
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neny injury or other traumatic event, the Madi once.		4 □ Donation 5 □ Other (Specify) Cape H	len.	lopen Crem.   3/16	/2006	Frankfor	rd, I	DΕ
portice.		21. Signatura Funda Service Licensee	22	2. Name and Address of Facility Th	ne Burba	ige Fune	ral F	Home
89 E 2 8	1	M. Talk Durlage		108 William St., I	Berlin,	MD 2181	1	
		23a. Part1. Enter the disease or complications that caused the death. Do n shock, or heart failure. List only one cause or each line.	ot ent	er the mode of dying, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition		Imonory Fi				Onset and Death
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p #	le l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	f):					
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The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	Pnysician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death		Ectopic pregnancy		23d. Date Mon	e of delive th	ry Day Year
by the a	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 [	Other (specify)				,
that the ed by detacl	5	Part II. Other significant conditions contributing to death but not resulting in	tho u	ndertring squee groon in Part I	23e Did to	obacco use contri	ibute to th	ne cause of death?
ires ti signe	6	Part II. Other significant continuous contributing to death out not resulting in	(ne u	ndenying cause given in Fait i.	1 🗆 1		3 ☐ Prob	
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	5				perfo 1 ☐ Yes	rmed? d	eath? □ Yes	2 🗆 No
Physicien: 1 r this certificer ral director, p	Re	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only o	nne)		
hysi this c	2 │	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out			ome 5 Resid			1)
ing P	<u>:</u>	I Giratoral D I offortig	ime o jury	Work?	28d. Describe h	now injury occurre	ed	
tendi leath. lor: A the fu	cat	2 Accident investigation		M 1 Yes 2 No				
br At fter d	Certification:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, str	eet, factory, office	28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rura	I Route Number,
urs a								
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifico completely filled in by the funeral director.	Medical	29a. Certifier (Check only a Medical Examiner: On the basis of examination and	deatl Vor in	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the red at the time,	cause(s) and mar date and place, a	nner as st ind due to	ated. the cause(s)
the the mplei	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date ≨igned	(Month	Day Year)
To With		230. Signature data wire or continer		2//// 83		Co. Date signed	, worth,	/ / Car
	1			177000		3/16	101	
- / 11		30. Name and address of person who completed cause of death (Item 23a) (	1	1. 7	Les	Birl		n. 1
OTI		31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	17	hands.	4	1166	-)	100
State Registra		31. Date filed (Month, Day, Year) 32. Philistrar's Signature	A	books				

			1 - For State Registrar	State of Ma	•	epartme <i>Certifica</i>			Mental Hy	/giene		09841
			Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
	Phys	ician dical	Helen Marie	Curti	Ln				Month	n 11	2006	11:08 P <sup>M</sup>
•	Exam		4a. Facility Name (If not institution, give s	treet and number)		4b. Ci	y, Town, or	Location of Dea	ıth	4c	. County of Death	
			Suburban Hospital					esda			Montgomer	7
	Funera	_	5. Social Security Number 6. Sex 1578-14-9660	:   7.Ag  M 2.2XIF	e (In yrs. last birth	rs. Month		If Under 24 Hr Hours Mir	n. (Month, D	irth a <i>y, Year)</i>	9. Birthi	place (State or Foreign
	Directo	or	Usual Residence of Decedent		89 '				April	1/,	1916 Wasi	nington,DC
	anyland show		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	a-fst	ctor	Maryland Montgom	ery	Bet	thesda						1 XYes 2 No
	iff the	Director	10e. Street and Number			10f. 2	Zip Code			10g. Ci	tizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show rnust be notified at	- a	6000 Namakagan Roa					316			U.S.A.	
	er dei Itams Der E	Funeral	T. Maritar Otatos	12. Was Decedent Armed Forces?		li .		spanic Origin? ( n, Mexican, Pue	Specify Yes or N into Rican, etc.)	0-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
	36 rs after	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	NO	1 ☐ Yes	2 No	Specify:			Specify: W	hite
	2 hou	ted	15. Decedent's Edu	cation	16a. I	Decedent's U	sual Occupa	tion		16b. K	(ind of Business/In	dustry
	21.5 Find 9 Find 2	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or :		life. DO NOT	vork done d use retired)	uring most of w	orking			
	21 and with a signal of	Completed	12			Н	omema				Own Hom	e
	be file tal Hy doth	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle		Sumame)	
	Y a	2	Raymond Hurley	Dist	10)		(0)	· · · · · · · · · · · · · · · · · · ·	Crowley		T 7	- 0 - 1 - 1
-	Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mantal Hygiene. It is marked othar than "natural", or traumatic event, it a Modical Evand traumatic event, it a Modical Evand		19a. Informant's Name/Relationship (Ty)	•		•			thesda,		or Town, State, Zij 20816	Code)
	1 and 1 and Healt Ism 2 ther		John J. Curtin, III	L SUII	20h Place of	Disposition /	lame of			-	ocation - City or To	own, State
	no ages out of the Hr	3	1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Gate o	y, crematory of f Heav ery	r other place en	) Mar	ch 18, 006	Sil.	ver Sprin	ng MD
;	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natural", or Itams 23a or 28a-f shoy any injury to other traumatic event, the Medical Examiner must be notified at	oj l	21. Signature of Funeral Service License	99 111	Cemete	22. Name	and Addres	s of Facility				16, 110
1	m Ferra	S S S S S S S S S S S S S S S S S S S	Murin 96 X	ell			W	222 Wis	eVol Function, D.C	Ave. 200	307 N.W.	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused ne cause on each li	d the death. Do no							Approximate Interval Between
	Priysicia	Tra a	Immediate Cause (Final disease or condition		Intracra	anial I	lemorr	hare				Onset and Death
	/Medica	al	resulting in death)		a consequence o							
Do	Examine		Sequentially list conditions,	)								
0	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of Injury)	Due to (or as	a consequence o	or):						
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0	ortificate refined by size as the	ed										
Q	Box auth cert attendin for use	M/CI	23b. was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Fetal death	3 □Ectopio	pregnancy				23d. Date of deliv	*
111	Geath death ne atten ed for u	100	in the past 12 months? 1 ☐ Yes 2 ☐ <b>X</b> No	4☐ Pregnant a		5 Other					Month	Day Year
7	P.O at the 1 by the	Physician/M	9 Unknown						00 01			
40	ords, P requires that een signed b	þ	Part II. Other significant conditions con	•	out not resulting in	i the underlyin	g cause give	n in Part I.				he cause of death?
	OFC requi	eted	Respiratory Fail	ire								
7	Vital Record sician: The law requir certificate has been si	Completed							24a. Wa auto	opsv	prior to co	ppsy findings available impletion of cause of
5	al F	ပိ									1 ☐ Yes	2 No
telen	of Vita Physician: this certific	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ▼ No	lospital: 1 🕅 Inpati	2 TER/Out	tpatient 3	Othe	-	eath (Check only		s Dother (Same	F.1
	Of Phy er this	1:1	27. Manner of Death	28a. Date of Inju	ury 28b. T	ime of	28c. Injury	at	28d. Describe		6 ☐Other (Speci iry occurred	(9)
2	Vision Attending r death. actor: After by the fune	atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Da	iy rear) in	njury M	Work	es 2 □ No				
工	Division  I or Attending after death. Diractor: Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	jury - At home, far tc. (Specify)	rm, street, fact	ory, office		28f. Location City or To	(Street ar	nd Number or Run	al Route Number,
urtin	talor rsafte ed in	Cer		55								
3	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the law requires that the death certificate be executed to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	29a. Certifier 1 Cartifying Physic (Check only 2 Madical Exami	nar: On the basis of	of examination and	, death occurr d/or investigati	ed at the timon	e, date and pla inion, death oc	ce, and due to the curred at the time	e cause(s , date an	i) and manner as s d place, and due t	tated. o the cause(s)
)	To tha h within 24 To tha F complete	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License				ate signed (Month,	
	5 <u>14 ki</u> 5	-	SDelistat	lus				59980	,		3/13/06	
	6		30. Name and address of person who co		death (Item 23a) /	Type Print)	<u> </u>				7(00	
	,		Sandra Delistathi		8600 01d		etown	Rd. Be	thesda.	MD 2	0814	
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	Regi	strar	MAR 1 6 20	36	U 16 1							

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Yaar ester :20 Am **Physician** 2006 Varin /Medical 4b. City, Town, or Bocation of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Baltimore Birthplace (Stata or Foraign Country) If Under 1 Yaar Months Days If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Hours 1□M 2 F 2/8-20-6592 Usual Residance of Decedent Yrs. 1926 May 11, Maryland Director 10d. Insida City Limits death with the Maryland 10c. City, Town or Location 10a. Stata 10b. County 1 1 Tayas 2 □ No MD Director altimore 10g. Citizan of What Country? 10e Street and Number 21230 USA 46 Funerai rre 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacadant Evar in U,S. Armad Forcas? 11, Marital Status 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: Pagas 1 and 2 should be filed within 72 hours after in and of health and Mental Hygiene. ant: if item 27 is marked other than "naturel", or ite in or other traumate event, the Medical Examine ray or other traumate event, the Medical Examine. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 Tho Spacify: ģ Black 3 ☐ Widowed 4 D Divorced Be Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Collega (1-4or 5+) Elementary/Secondary (0-12) Assistant 12 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Rita Brannock James anks 2 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 1046 W. Barke Street Baltinoke, MD. 21230 Tamaka Jackson McNair 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20c. Location - City or Town, Stata Date 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Department of important: if any injury or 3/18/06 Cambridge, Beckwith Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22 Name and Address of Facility Home, P.A. Henry Funeral Home, P.A. 21. Signature of Funeral Service Licensec 23a. Part. Enter the disaasa, or complications that caused the feath. Do not enter the mode of dying, suid as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Cambridge, MD, 2/6/3 Approximate Intarval Batween Onsat and Death Physician Arhyth mia Immediata Cause (Final disaasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requiras that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23h. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an autopsy parformad? 1 | Yes 2 | No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 1 ☐ Yes 2 ☑ No 26. Place of Daath (Chack only one) Be Hospital: Other: 4 Nursing Homa 5 Residance 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Division 1 Natural 5 Panding invastigation 1 Yes 2 🗆 No 2 Accidant i Director: 6 Could not be datermined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

To the Hospital or Attendin within 24 hours aftar daath. To the Funerel Director: Aft

State

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) R 1 4 2006 Registra

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29b. Signature and title of certifier

32. Registrar's Signatura

Rowen Blud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Dirolin

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 06<sup>Year</sup> Month **Physician** - 24 MARTHA NOVELLA DUNCAN 10:30 P M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 213-18-2846 92 Yrs. Director 8-21-13 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Count rel', or items 23e or 28e-f show Examiner must be nedfilled at 1√2 Yes 2 □ No Director ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 170 CENTER STREET 21532 U.S. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Importent: If item 27 is marked other the any Injury or other traumany injury or other traumany. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 2√2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN BEAUTY SHOP 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be JOHN STEVENSON MARY CATHERINE ANDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SANDRA DeLORGE DAUGHTER 2120 TIMELESS DRIVE ST. LEONARD, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 3-27-06 FROSTBURG 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 WEST MAIN STREET SOWERS FUNERAL HOME, P.A. m00547 Sowar3 FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Chronic **Physician** /Medical Examiner Tobacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28 2006 D 14464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, MD 21532 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 3 0 2006

			1 - For State Registrar	State	of Maryla		artment of I			gieņe Reg. No.	6	09844
	D		1. Decedent's Name (First, Middle	e, Last)	-				2. Date of De	ath		3. Time of Death
	Physic /Medi		VIRGINIA :	LEE DOV	NEY				MARCH	25 <sup>Day</sup> 200	) $e^{Xear}$	2155 p M
	Exami		4a. Facility Name (If not institution				4b. City, Town, o	or Location of Dea	th	4c. County	of Death	
			Chester Rive				Cheste				ent	
	Funeral Director		5. Social Security Number 212-32-0159	6. Sex 1 ☐ M 2√2 F	7. Age (In y	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min		y, Year) 1929	Cou	place (State or Foreign ntry) Yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation				1.	10d. Inside City Limits
	Mary Fe sh	to	MD Kent	5	Cl	nester	town					1 ☑ Yes 2 □ No
	th the	Director	10e. Street and Number		Į O1	ICBUCI	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	23a c		202 Pine St.				21620			U.S.	Δ	,
	tems er ru	rue	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H	dispanic Origin? (S	Specify Yes or No-	14. Rac	e - Americ	can Indian,
5-0036	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or Items 23a or 28a-1 show event, ir a Medical Examil or mast be multiled as	by Funerai	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Gir Year or D	/8		1□Yes 2∏2No	Specify:	10 1 110411, 010.7	Specify	k, White, W}	nite
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and	ntal H ad ot ad ot	Be	17. Father's Name (First, Middle, I	.ast)					me (First, Middle,		-,	
Maryland	should by nd Menta nmarkad umatic ev	2	19a. Informant's Name/Relationsh	in (Tuna Print)		105 Maili	a fielder - /China		ret Min			
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altimore,	+ E # -		21. Signature of Funeral Service 1			22	. Name and Addre	ss of Facility				wn, MD.
מ	Depa Impo any ii		1700		мос	Ga	ilena Fi	moral	Home of	Steph	en I	Schae
			23a Part. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the de	ath. Do not ent	er the mode of dyin	g, such as cardia	or respiratory arr	ena, M est,	IJ•	Approximate Interval Between
	nysician -		Immediate Cause (Final disease or condition	Con	as it	ive 1	Jonat	Failur	2			Opset and Death
	/Medical Examiner		resulting in death)	Due to	or is a conse	equence of):	1	1 0	1.			J Oury s
	_xammer	4	Sequentially list conditions,	b. /	PEYLO	sclex	roha	hear	े नार	110	X	YRAYS
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00/00	fficate be executed g physician and is the burial-transit	aiE		(		,			10 0			
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Y O	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of preg					23d. Date	of delive	rv
	deat	sicia	in the past 12 months?	4☐Pregn.	irth 2 □ Fe ant at time of		Ectopic pregnancy Other (specify)			Mon		Day Year
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2	s certificate has b irector, page 2 s	0							perform	ned2 di	eath?	2 No
<b>*</b>	Siciar	o Be	25. Was case referred to medical examiner?	Hospital:			Otho	-	th (Check only on			· · · · · · · · · · · · · · · · · · ·
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5	s after or safter  Cert	4   Homicide	buildin	g, etc. (Spec	ify)			City or Town	, State)			
		edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the	sis or examin	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the ca	iuse(s) and man	ner as sta	ated. the cause(s)
:	o the omple		29b. Signature and title of certifier	and mann	er stated.		29c. License			9d. Date signed		
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	6		30. Name and address of person w	no completed call	of death (Ite	m 23a) (Tvna F		, 00	-	121	~ 0 (	Ψ
	フ	3		10			•	Hill DA	Chac	- orton	n M	D. 21620
	Stat		Wayne D. Ben 31. Date filed (Month, Day, Year)	32. R	trar's Sign	ature		NO.	- cuesi	PETFOMI	1, 1	U. ZIBZU
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DHMH 17 Rev 1/2001

06-02008 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a.27 perME C854. 4/13/06 TT State of Maryland / Department of Health and Mental Hygiene Edward L. Dize RJD . Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Physician "Gizzard" March 21, Edward L. Dize 2340 P. <sup>™</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** M 2□ F 213-44-0805 68 10/10/1937 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rthen "natural", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 Yes 2 □ No Directo MD Somerset <u>Princess Anne</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11754 Mansion Street 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: δ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood none 17 le marked othe traumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked oth any jujury or other traumatic event anges. Be Cloyd Dize Louise French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Dize/Son 31084 Cooper Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory |03/24/2006 | Salisbury, Maryland 21. Signature of Funeral Survice Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853
Approximate shock, or heart failure. List only one cause on each line.

M00295 11673 Somerset Ave., Princess Anne, MD 21853
Approximate Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an certificete has t irector, page 2 s autopsy performed? 2□ No 1₽ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA scene this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. March 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201 Tasha ZCiveenberz M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Elsew & Sparke MAR 2 7 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 05 15 M Dorothy Ann Dennis MARCH 200G /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peni Nsula Regional 5A4sky Medical Hicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 3, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 54 MD Director 215-58-5589 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov 1 X Yes 2 ☐ No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with ament of Health and Mential Hygiene.
ament of Health and Mential Hygiene.
The Transport of the Transport of the Mention of 511 Truitt St. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerk Video Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oather Mumford, Sr. Mildred Tingle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawson Dennis/husband 511 Truitt St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) New Bethel UMC Cem 3/18/2006 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility alaxa Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** Respiratory facture F-15 MS1S one year /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executes. Due to (or as a consequence of): Examine physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Day Year 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? Yes 2 No certificate 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 she ruly DO57359 March 14th 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415. S. DIVISION SALISBURY MOXES 4 DR. USITA MARIJAN 31. Date filed (Month, Day, Year) 6 32. gistrar's Signature State Sporte Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Robert Elwood Davis 14 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Mar 30, 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 **X**M 2 ☐ F Yrs. Director 61 212-40-9972 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Exerciper must be notified at 1X Yes 2 □ No Director Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 10218 Old Ocean City Blvd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w. h and Mental Hygien 7 is marked other th Truck Driver 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elwood Tingle Marjorie Williams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Ophelia Davis/wife 10218 Old Ocean City Blvd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 3/18/2006 Berlin, MD 21811 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lewis N. Watson Funeral Home AWalson 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician obstruct, chrosic 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner It any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (HO 2 1 Tyes ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, MAR 1 6

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	/Medic			a Dav	•						MARCH	11 2	1006	1035 AM
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			ANCHORAGE NURSING					SALIS	BURY If Under	24 Hrs	O Data of Birth		COMICO	
	Funeral		5. Social Security Number 6. S 214-03-1480	ex 7. Ag □M 2ŽXF	ge (In yrs. Ia 89	est birtnaay) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day DEC • 25	Year) 1916	COU	place (State or Foreign htry) RGINIA
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	/land		10a. State 10b. County		10c. City	Town or Lo	cation						1	0d. Inside City Limits
	Mar Hed	to	MARYLAND WICOMI	.CO	W:	ILLARD	S							1 ☐ Yes 2 X No
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	ems	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	3. 13.	Was Dece	dent of H	ispanic Ori n, Mexicar	igin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)		lace - Americ	
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Baltimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene.  If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, In a Medical Examiner meat he retified at		20a. Method of Disposition 1 DBurial 2 Cremation 3 D	Bemoval from State		ace of Dispo	sition (Na matory or	me of other plac	e)	(	Date	20c. Locatio	n - City or To	own, State
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Ш	70 E # 9		Marly W. G	in	-						ME, SELI		E, DE.	
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89	tifical og ph as th									-				
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P.O.	that the death ed by the atte detached for	Physician/Med	9 Unknown			Min in the co	and and the second		:- P1		220 Did to	bacco uso o	natabuta to t	ne cause of death?
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oro	v requii been s shoutd	eted												
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	dical (	29a. Certifier 1 Certifying Pt	nysician: To the best miner: On the basis	of my know	viedge, deat	h occurred	at the tin	ne, date an	nd place,	and due to the o	ause(s) and	manner as s	tated.
	To the H within 24 To the F complete	a)	one)	and manner s										
	L T T T	Σ	29b. Signature and title of certifier  NA PS				29	c. License	109	u	1 2	29d. Date sig		
6	114					: -						5/	13/06	
7	10		30. Name and address of person who  VEL NATEAN  31. Date filed (Month, Day, Year)	completed cause of	death (Item	23a) (Type,	Print)  V ST	uv	5 A1	LISBV	My M	3 2/81	04	
V	Sta	ite	31. Date filed (Month, Day, Year)	6 200 G2. Regis	ar's Signat	ure L	1							
	Registi		MAK I	2000	been	D.	900	EL)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** PHILLIP F. EPLING, JR. March 15, 2006 4:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6603 Patterson Street Prince George's Riverdale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F 75 Yrs Director Oct. 13, 1930 Virginia 578-42-6103 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 ☐ No Mary1and Prince George's Riverdale Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ or Items 23a 6603 Patterson Street 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: ģ 3 X Widowed 4 □ Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Itam 27 is marked other th any injury or other trees. 3 Linesman Electrican US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Phillip F. Epling, Sr. Marie Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul D. Epling - Son 763 Whitneys Landing Road, Crownsville, MD 20132 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial /2 □ Cremation 3 □ Removal from State 4 □Donayon 5 □ Other (Specify) Fort Lincoln Cemetery 3/17/2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Uchell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner erebro Vase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed did arlung Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai es the t IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Lipideemis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy 25. Was case referred to medical 1 Tyes 2 💢 No Physicien: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 58 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A11883 March 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9470 Annapolis Road, Lanham, Maryland 20706 Hema P. Yadla, 32. Resistrar's Strong MAR 1 6 2006 Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dealh Month Year 11:11A M **Physician** 1,011 1 a arch 2006 INP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** J. MPSON 6. Sex chester 000 M DY I QG Year If Under 24 Hrs. Days Hours Min. a If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 1 F 89 Months 220-03-030 1916 Mary Yrs. Director lano Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 la markad other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Exact in an invalue te really and 1 TYes 2 No Funeral Director Mbridg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U. S. A. 14. Race - American Indian, SON χ 00 161 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) icker Dea 1-00d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F permit. Pagas 1 and 2 should be Department of Health and Mental Important: If item 27 Ia markad c any injury or other traumatic evegates. 105e VICNAMar Angle Travers 19b. Mailing Address (Street and Number or Miral Route Number, City or Town, State, Zip Code) 2/622 19a. Informant's Name/Relationship (Type, Print) 3247-Blackwater Rd, Church Creek, M.D. MOIOCK 5 0 m 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 3/13/06 Church Creek, MD Nevs Rd, Cometery! ignature of Funeral Service Licensee

22. Name and Address of Facility

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1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the ba detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably al With Be Completed age 2 sh 24b. Were autopsy findings available prior to completion of cause of death?
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28d. Desire how injury occurred Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death Director: / filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State 'Registrar 30. Name and address of person w Je

bric

31. Date filed (Month,

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

Widmate, M.D.

Widmate

2006 32. Reg rar's Signature

D0061872

503 Byrn St. Combitage, MO 21613

			Please Type or Print in B State of Maryland 1- For State Registrar	d / Depa		ealth and I	Mental Hyg	•	119852
	Physici /Medio		Decedent's Name (First, Middle, Last)     LARRY CORDELL F	ISHE	<b>\</b>		2. Date of Dea Month March	Day Year 7, 2006	3. Time of Death 2140 M
<b>)</b>	Examir Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  Holy Cross Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. In Security Number)  579-66-6563	ast birthday) Yrs.	4b. City, Town, or Silver If Under 1 Year Months Days	Sprin	<b>3</b>	4c. County of Dea Montgoi (, Year) 9. Bir (, Year) 9. Bir (, Year) W.	
	ס	Director	Usual Residence of Decedent   10a. State   10b. County   10c. City   MD   Montgomery   RC   10e. Street and Number	Town or Loc	10f. Zip Code			10g. Citizen of What Co	10d. Inside City Limits 1 □Xes 2 □ No
000	within 72 hours after death with the Marylan plene. Then "natural", or iteme 23a or 28a-f show the Madical Examiner must be notified at	d by Funeral	12630 Veirs Mill Road #311  11. Marital Status 1 Never Married 2 Married Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates:	S.   13. W	2085  Vas Decedent of Hir Yes, specify Cubar □ Yes 25%  No		pecify Yes or No- o Rican, etc.)	U.S.A.  14. Race - Ame Black, White Specify: B.	te, etc.
.CI7I7	iled within 72 Hygiene. Iher then "na Int, the Medic	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last)	(Give k life. D	enl's Usual Dccupa kind of work done d 10 NOT use retired, Ceptioni	lu <i>ring</i> most of <i>wor</i> ) LSt		Salvatio  Maiden Sumame)	
Maryland	m - 0 =	To Be	William D. Fisher  19a. Informant's Name/Relationship (Type, Print)  Geneva Shavers- Mother			Gene	va Sha	avers	Zip Code) le,MD20853
ballimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tem 27 is marked any injury or other traumatic espace.		20a. Method of Disposition 20b. Pl.  1 SuBurial 2 Cremation 3 Removal from State	sh Nat		3/1 s of Facility S			
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=	on Men	Certification; 1		28b. Time of Injury	28c. Injury Work M 1 🗆 \		28d. Describe h	ow injury occurred	
	To the Hospital or Attendi within 24 hours after death , To the Funeral Director: / completely filled in by the fr	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.		estigation, in my op	pinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
)	Tot with Co	Ň	30. Name and address of personanto completed cause of death (Item		Print)	7867		March 1	
e E	Sta Registi	rar	Dr. Ziniga Oney, 4701 Rand 31. Date filed (Month, Day, Year) MAR 16 2006 32 Registrar's Signat	ure /	Road Ro	OCKVIII	e, MD	20852	

			/ Department of Health and M	lental Hygiene	۵	
1	• .	1 _ Stata	Department of Health and M Certificate of Death	Reg. No		3
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Physic		Mary Heary Fletch	er	Month Da	6 30 6:30	Рм
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town or Location of Death	1.55	c. County of Death	,
		1723 Cedar Park Road			9. Birthplace (State or F	e
Funera		5. Social Security Number 6. Sex 1 M 200 7. Age (In yrs. last	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 10-06-14	r) Country)	
Directo		Usual Residence of Decedent		10 00	10d. Inside City I	
irylan show	_	Tou. State	own or Location		1 XYes 2	
he Ma 88a-1s	ecto	MD Anne Arundel  10e. Street and Number	Annapolis  10f. Zip Code	10g. C	itizen of What Country?	
ary IZITIO Z LZ I 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural; or itema 23a or 28a-f show umatic event, the Medicul Evantinal must be treitified at	Funeral Director	1723 Cedar Park Road	21401		USA	
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Box bath cer attendin for use	lcian/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/mths?  4 □ Percent at time of deal	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Ye	ear
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	y Physi	Part II. Other significant conditions contributing to death but not resulting		23e. Did tobacco	o use contribute to the cause of dea	
cords w requires been sign	q pa	Chronic deep Venaus +	Monbo embolus	1 🗆 Yes	22No 3 Probably 4 □Un	ıknown
Records, ne taw requires to the taw seen signetige 2 should be of	Completed by	with Chronic pulmonar	y lombolic	24a. Was an autopsy	24b. Were autopsy findings av prior to completion of cau death?	vailable use of
The traction of the page	Com	phenomena	(	performed?		
Vital F sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)	6 □Other (Specify)	
Of Phys	1: To	1 res 2 vivo	28b. Time of Injury Work?	28d. Describe how in		
ion nding ath. r: Afte	ation	1 ☑ Accident investigation (Month, Day Year)	M 1 Yes 2 No			
Division of a or Attending Physical death.  Director: After this din by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number ate)	er,
Division (  Hospital or Attending F  24 hours after death.  P Funeral Director: After etesty filled in by the funer	Ce		ledge, death occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.	
Division of Vita No. Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: After this certifical completely filled in by the funeral director:	edical	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occu	irred at the time, date a	and place, and due to the cause(s)	
To the h within 24 To the I	Me	29b. Signature and tine of certifier	29c. License number		Date signed (Month, Day, Year)	,
		I ham to broth m.o	0005032	-1 0	13-07-200	26
		30. Name and Vidress of person who completed cause of death (Item 2	23a) Type, Print) Tidewates	- (olony )	3-07-200 Annapolis KIVE MD 21-	101
长。	State	32 Registrar's Signatu		1		1-1
	ictror	MAD 1 9 2006	M. Something			

		4	For State Registrar	State	of Maryland		artment <i>tificate</i>			and M		giene leg.No.)	16	09854
			1. Decedent's Name (First, Middle, L								2. Date of Dea Month	Pay 14,	2006	3. Time of Death
	Physicia /Medic		Edward Gr							15 11	March			5:03 P. M
	Examin		4a. Facility Name (If not institution, g				•		Location of	of Death		Cari	nty of Death	1
			Longview Nurs	Ing Home	7. Age (In yrs. I	ast hirthday)	Mano If Under			24 Hrs.	8. Date of Birth			place (State or Foreign
	Funeral Director		5. Social Security Number 6. 112-12-4356	1 ☐ M 2 ☐ F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 3	, Year) 1917	Mas	sachusetts
		-	Usual Residence of Decedent	A										
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	a-fs	ctor	Maryland Carrol	1	We	stmins								1 Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip					10g. Citizen		untry?
	ath w	Funeral Director	942 Westcliff Co		andert Everin II	c   12 1		1158		gin? (Sp	ocify Yes of No-		S. A.	rican Indian.
	er de Items	ine	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed F		1	f Yes, spec	fy Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
50	irs aft	by F	3 ₩ Widowed 4 Divorced	If Yes, G Year or	ive		1□Yes 2	2 <b>∏</b> No	Specify:			Spe	ecity: Wh	ite
5-003p	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ont, the Medical Evantratinast kerncillied at	ted	15. Decedent's	Education		16a Dece	dent's Usua kind of wor	Occupa	ation	t of work	ing	16b. Kind o	f Business/l	ndustry
212	hin 7.	ple	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT us	e retired	)		9			
7	ad wit	Completed	12 Years			Sale	esman		40.14.45		/First Middle		Lquor	
2	0 7 >	Be (	17. Father's Name (First, Middle, La	ist)				1			(First, Middle,	маюеп Зиг	name)	
<u>Ş</u>	should be find Mental Harked ol	2	Max Greenfield	(Time Grint)		10h Maili	na Address	(Street	Ma and Numb		al Route Numbe	ar City or To	wn. State. Z	(in Code)
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship Elyse B. Markwi		ughter						estmins			
	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of	1		Date		on - City or	
õ	Pages nent of ant. If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		n State I	emetery, cre. Lean Me				3/17	/2006	Olney	, Mar	yland
Baltimore,	artme ortan injur		21. Signature of Funeral Service Li		1040									-
ñ	Ded Imp		Donald (	Xto	ttlemy	22 10	1ward 191 Ro	ockv	ille	Pike	l Direc , Rockv	ille,	Maryl	and 20852
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications than	t caused the death	h. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		Cardion	_								5 Years
	/Medical		resulting in death)	Due t	o (or as a conseq									
H	Examiner	_	Sequentially list conditions,	b	Arterio		otic \	Vasc	ular	Dise	ase			25 Years
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	0 (01 23 a conseq	derice ory.								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):		_						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	dical		d										
Ö	tificat ig phy as th	ledi												
Box	leath certifice attending ph I for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		⊒Ectopic pi	regnancy	,			23d	. Date of del Month	ivery Day Year
	e deal	Physician/Me	in the past 12 months?	4□Pre 9□ Uni	gnant at time of d known	leath 5	Other (sp	oecify) _						
P.O.	that the de led by the a detached f	Phy	9 Unknown Part II. Other significant condition	e contributing to	death but not res	sulting in the I	underlying o	ause div	en in Part	l.	23e. Did t	obacco use	contribute to	the cause of death?
	w requires that been signed be should be det	by	Part II. Other significant conduct	is contributing to	dodin but not roc	, diling in the		, g.,			10	Yes 2√⊡N	lo 3□Pi	obably 4 Unknown
Vital Records,	need	Completed									24a. Was		4b. Were au	utopsy findings available
Rec	has ye 2	mp							-		auto perfo	psy rmed? 2 X No	death?	completion of cause of
<u></u>	n: Tł ficate or, pa	e Co	25. Was case referred to medical	-11					26. Plac	e of Dea	1 ☐ Yes		1 🗆 103	2010
	s cert	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DC	Oth	ier: 4X N	lursing H	ome 5 ☐ Resi	dence 6	Other (Spe	city)
o	g Phy er this	i.i.	27. Manner of Death	/8.4	te of Injury onth, Day Year)	28b. Time	of 2	28c. Inju	y at rk?		28d. Describe	how injury o	ccurred	
ion	ath. vr: Aft	atio	1 Natural 5 Pending 2 Accident investig	ation	······,, · · · · · · · · · · · · · ·		М		Yes 2	]No				
Division	r Atte	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Pla	ace of Injury - At h ilding, etc. (Speci	iome, farm, s	treet, factor	y, office				Street and N wn, State)	lumber or R	ural Route Number,
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page.	Cer	37	<u> </u>			th are '	l at the cit	mo deta	and place	and due to the	causo(c) co	d manner a	s stated
	Hosp 14 hou Fune tely fi	edical	29a. Certifier 1 \(\infty\) Certifying (Check only one) 2 \(\infty\) Medical E	xaminer: On the	the best of my kno basis of examina anner stated.	owiedge, dea ation and/or i	nvestigation	at the ti	me, date a opinion, de	ath occu	red at the time,	date and pla	ace, and du	e to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	handin	0 1 a		29	c. Licens	se number			29d. Date s	igned (Mon	th, Dey, Year)
			& John M.	11 has	Stil			D25	6443			Marcl	n 15,	2006
•	3		30. Name and address of person v	vho completed c	ause of death (Ite	m 23a) (Type	o, Print)							
			Dr. John Mic	dleton	688 Poc	ole Roa	ad, Su	iite	C, W	estm	inster,	Mary]	Land	21157
		ate	31. Date filed (Month, Day, Year)	32	2. Abgistrar's Sign	ature	parke	P						
	Regist	16.1	MILLIO T (	, CUUU   2		100								

		1 - For State Registrer	State o	f Maryla		artment <i>rtificate</i>			ınd M	ental Hy	giene	<b>3</b>		r Ar ma
Physici /Medio		1. Decedent's Name (First, Middle,  Morris Gre								2. Date of Dea Month March	Day	Year 2006	3. Time of Pea 8:50 A.	
Examir		4a. Facility Name (If not institution,						Location of	f Death			nty of Deatl		
		Hebrew Home of  5. Social Security Number	Greater S. Sex		gton s. last birthday)	Rock		1e If Under 2	24 Hrs	8. Date of Birti		ntgome		
Funeral Director		083-10-1658 Usual Residence of Decedent	1□M 2□F		39 Yrs.		Days	Hours	Min.	Jan. 25	/, Year)	7 Nev	nplace (State or For untry) V_York	reign
ith the Maryland or 28a-f show	tor	10a. State 10b. County  Maryland Montgo	omery		City, Town or Lo	ocation				1,3			10d. Inside City Lin	
with the sa or 28a	Direc	10e. Street and Number 11905 Judson Roa				10f. Zip (	Code 0902				10g. Citizen	of What Co	•	
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit neat of Heatin and Mentalle Hygiene.  Dippartment of Heatin and Mentalle Hygiene.  San or 28a-f show any injury or other traumatic event, In a Medical Examinating the notified an once:	by Funeral Director	11. Marital Status  1 □ Never Married 2(  Married 3 □ Widowed 4 □ Divorced	12. Was Dec	2 No A.I	rmy	Was Decede		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. F	Race - Ame Black, White	ncan Indian,	
in 72 hou n "natura natical E	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a, Dece	dent's Usual kind of work DO NOT use	Occupa k done d e retired	ation luring most	of working	ng	16b. Kind of	Business/	ndustry	
d withi giene. ir than	mo	Elementary/Secondary (0-12)	2 Yea	1-4or 5+) <b>YS</b>		tal Se					U.S.	Gove	nment	
ild be filed lental Hyg rked othe	To Be C	17. Father's Name (First, Middle, L Abraham Greele								(First, Middle, Strasou		name)		
od 2 shou lith and M 27 is mar		19a. Informant's Name/Relationshi Edward C. Greele								Route Numbe				· -
Pages 1 ar ent of Hea nt: if Item 3		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.	3 □Removal from	20b. State	Place of Dispo cemetery, cre idean M	osition (Name matory or oth	e of her place	9)	D	2006	20c. Locatio	on - City or		
permit. Departm Departm Importa any inju		21. Signature of Funeral Service L		***	É I	dward 091 Ro	Addres Sag ockv			l Direc			-	52
And project of the private of the pr	ical Examiner	23a. Part1. Enter the disease, or can shock, or heart failure. List of the shock of	aP  Due to  C	neumon: (or as a conse	ia equence of): ive Hea equence of):				cardiac o	respiratory ar	rest,		Approximate Interval Betweer Onset and Death	h h
The law requires that the death certificate law requires that the death certificate lae has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		ointh 2 ☐ Fe nant at time of	tal death 3[	⊒Ectopic pre ⊒ Other <i>(spe</i>						Date of deli	very Day Year	
w requires that been signed b	by	Part II. Other significant condition Senile Dement		eath but not re	esulting in the u	inderlying ca	use give	en in Part I.		23e. Did to 1 ☐ Y 24a. Was i	es 2X∏No	3 □ Pro	the cause of death	own
slcian: The law scertificate has b lirector, page 2 s	Completed									autop	sy	prior to death?	ompletion of cause	of .
slcian certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		7-5-6		Othe	ac .		(Check only of				
ding Phys h. After this funeral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date (Mor		28b. Time of Injury		Bc. Injury Work	4X Nur	2	ne 5 🗌 Resid		- ' '	ify)	
To the Hospital or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigs 3 Suicide 6 Could not determine	ot be 28e. Place	of Injury - At ing, etc. (Spec	home, farm, st					28f. Location (S City or Tow		mber or Ru	ral Route Number,	
To the Hospital within 24 hours To the Funeral completely filled	edicai (		Physician: To the xaminer: On the band man											
To th withir To th comp	Me	29b. Signature and title of certifier	_	110				number			29d. Date sig			
1.		1 Danlor	ia 1	alar	ung		35	436			March	13, 2	2006	
φ,		30. Name and address of person w	·				Ro	ckvi1	1e. 1	Marylan	id 208	352		
Sta Registi		31. Date filed (Month, Day, Year)		legistrar's Sign		and i								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

-		For State Registrar	State of M			tificate of			Reg. No.	10 1	00000
Physicia		1. Decedent's Name (First, Middle,						2. Date of De Month	eath Day	Year	3. Time of Death
/Medica		Jennie Gosha G						Marc		2006	2:20 AM
Examine	er	4a. Facility Name (If not institution, g					or Location of Deat			y of Death	
	4.	SALISBURY REHAB					RY, MD. 2	1804	WICC	OMICO	
Funeral Director		422-30-2283	. Sex 7. Ag 1 ☐ M 2 ☐ <b>M</b> F	ge (In yrs. Ia: 83	Yrs.	Months Days	Hours Min.		1922 1922	9. Birthpi Coun	lace (State or Foreign try) Alabama
death with the Maryland me 23a or 28s-1 show rinust be indiffed at	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				11	0d. Inside City Limits
Ba-f o	Director	MD Wicom	ico	Ede	en						1 ☐ Yes 2 ☐ No
er er	<u>o</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
ath v ath v 23a	ē	14139 Backbone 1				21822				USA	
item from	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	?	. 13. V	Vas Decedent of F Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	14. Ha	ce - Americ ack, White,	
030	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No	1	□Yes 2√ No	Specify:		Speci	b:Blac	k
215-C 215-C thin 72 h	Completed	15. Decedent's (Specify only highest	grade completed)	E.)	(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of wo	rking	16b. Kind of E	Business/Inc	iustry
Signal Artificial Signa	E	Elementary/Secondary (0-12) 7th	College (1-4or	5+)		Labor	er		V	ariou	S
S of Hyself	Bec	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle	, Maiden Suma	me)	
Menta Menta	To E	Charlie Gosha					Elsie	Gosha			
Maryland d 2 should be fill the and Mental H. It is marked out treumatic even		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or Town	n, State, Zip	Code)
, N aalth n 277		Jeanette Frisby,	/daughter				e Rd., E	den, MD			
Or Heart roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Bompyol from State	20b. Pla	ice of Dispoi metery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	wn, State
and a garage		4 Donation 5 Other (Spe		Gree	en Acr	es Mem P	ark 3/1	8/2006	Salisb	oury,	MD
Baltimore, permit. Pages 1 at Department of Heal Important: if Itam any injury or othe page.		21. Signature of Funeral Service Lie	cense /		I	Name and Addre	Watson F	uneral H	Home	001	
en en en		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death.	Do not ente	er the mode of dyn	Rd., Sa ng, such as cardia	c or respiratory a	rrest,	101	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	my one cadsground acrim			0.16					Onset and Death
/Medical		resulting in death)	a. Due to (or as	a conseque	age of.	200 Y	12 N				7201-
Examiner			· ence	Rod	nee	2 V.	rel			e	ear-
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	enge of):			Δ			
68760, ifficate be executed g physicien and as the burial-transit	Examiner	that initiated events	c. seer	Jeh,	and	O.a.	colon	Den	ease	19	Dar-
e exe	Ä	resulting in death) Last	Due to (or as	a conseque	ence of):						
68760, ficate be ex physicien	edical		d					-		:	
c 68		IF FEMALE:									
Box leath cert attendin	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal c	death 3	Ectopic pregnanc	y			ate of delive	ny Day Year
O. In the de the	by Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of dea	ath 5∟	Other (specify) _	<del>-</del>				,
P. P. Getad detac	۲.	Part II. Other significant condition	s contributing to death b	out not result	ting in the ur	iderlying cause giv	ven in Part I.	23e. Did 1	tobacco use cor	ntribute to th	e cause of death?
Division of Vital Records, P.O. Box 68760, 1 or Attending Physicien: The law requires that the death certificate be execut after death.  Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-trans.	b D							1 🗆	Yes 2 ₽No	3 □ Prob	ably 4 Unknown
w red should should be sho	Completed							24a. Was	an 24b.	. Were autor	psy findings available
Re(he lav	щ							auto perfe	psy ormed?	prior to con death?	npletion of cause of
Vital F sicien: Th certificate	ပိ	25. Was case referred to medical					OC Place of Do	1 Yes		1 🗆 Yes	2 No
Sicie Scent lirect	Ö	examiner?	Hospital: 1 ☐ Inpatie	ent 2 TE	R/Outpatien	t 3 DOA Ott		ath <i>Check only</i> d Home 5 ☐ Resi		hor (Specifi	,)
Of Phys arthis	-	27. Manner of Death	28a. Date of Inju		28b. Time of	28c. Inju			how injury occu		/
on oding :: Afte	Ē	1 Matural 5 Pending 2 Accident investiga		ay Year)	Injury		rk? ]Yes 2 ☐No				
VISI Atter octor by the	Certification:	3 Suicide 6 Could no determine	289, Flace of In	jury - At hom	ne, farm, stre	eet, factory, office		28f. Location (	Street and Num	ber or Rura	l Route Number,
Div s afte of in	Sert	4   Nothicide	building, et	tc. (Specify)				City or To	wn, State)		
	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place	nanner as st , and due to	ated, the cause(s)
To the Within 2 To the comple	Me	29b. Signature and title of certifier	2//			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
		100 MI	for the same of th			0	> SAS	19	3/	10/2	
1		30. Name and address of person when the same address of person when th	no completed cause of	death (Item 2	23a) (Type	Print)	0/9/	/	1/6	2/00	0
11		WILLIAM ROBINS,					RY, MD.	21804	t	-	
Stat Registra		31. Date filed (Month AR, Yar6	2006 32 egistr	rar's Signatu	1	arli					

			1 - For State Registrar	State	of Marylan	•			ealth a D <i>eath</i>	and M	-	giene 06		9858
			1. Decedent's Name (First, Middle	, Last)							2. Date of De		ear	3. Time of Death
Н	Physicia /Medic		Ca	therine	Daisy	Hare					Mar.	24 200	5	6:19A M
i.	Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c. County of		
П			500 Fairmont	Avenue				son				Balt:	imo	re
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	Coul	
Н	Director		216-24-8043	1   M 2   2   2   1   1   1   1   1   1   1	80	Yrs.					Aug. 24	4, 1925 M	lar	yland
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation						1	10d. Inside City Limits
	Aaryl f aho	ъ.	11 D-1		ш.									1 Tes 2 No
	28a-	Directo	Maryland Bal  10e. Street and Number	timore	10	wson	10f. Zip	Code				10g. Citizen of Wha	at Cou	ntry?
	3a or	0	500 Fairmont	λυουμο				2	1286			TTC	SA	•
	death ms 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		Americ	
٥	after or Ita		1 ☐ Never Married 2 ☐ Marr	ed 1 Tes	2 [X No	į .	τ Yes, speα 1 □ Yes		n, Mexican Specify:	, Puerto	Hican, etc.)		White,	etc.
3	be filed within 72 hours after death with the Maryland stat Hygiene. od other then "natural", or Itams 23a or 28a-f ahow event, the Medical Examinat must be rectified ut	Completed by	3 XWidowed 4 ☐ Divorced	If Yes, G Year or D	Dates:		1 1 1 1 1 1 1 1	2 2 3 190	эрөспу.			Specify:	Wh	ite
بر م	72 h 'natu	etec	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced (Give	tent's Usua kind of wo	d Occupa	ation <i>furing</i> most )	of worki	ng	16b. Kind of Busin	ness/In	dustry
2	ne	d H	Elementary/Secondary (0-12)	College (	1-4or 5+)		nema}		)			Orano II	0 770 /	_
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<u> </u>	d 2 sho th and t7 Is ma trauma		Peggy Hare		ter	1	_					=		MD 21053
ā,	1 and 2 Health tam 27 other tra		20a. Method of Disposition	, Daugii		lace of Dispo emetery, cren				C	ate	20c. Location - Ci		
ᅙ	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		State	emetery, cren ldleto					28,	Exacla:	٦.	MD 21053
Baltimore, Maryland 21215-0036	permit. Page Department Important: Il any injury o		21. Sanature of Funeral Service	17	/ 1410	22	. Name an	d Addres	s of Facility	y .J		tenstei	n M	ortuary h
ñ	Per Per Per Per Per Per Per Per Per Per			ariens	Touri	24	1 Sec	cond	l St.	Ne	w Free	dom, PA	1	7349
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	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifyin	g Physician: To the Examiner: On the b	e best of my know	wledge, death	occurred	at the tim	e, date and	d place, a	and due to the d	cause(s) and mann	er as s	tated.
	the hin 24 the F the F	Medical	one)	and mar	ner stated.					_				
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cian	Decedent's Name (First, Middle     RICHARD		ALLEN HARR		S				Date of Dea Month	Day	Day Year		3. Time of Dea	
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al	5. Social Security Number	6. Sex		. last birthday)	If Under 1	Year If C	Inder 24 F		Date of Birth (Month, Day	h v. Year)			lace (State or I	
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	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation						<u>_</u>	1	0d. Inside City	
ţō	MD PRINCE	E GEORGE	S	UPPER	MARLB	ORO							1 <b>X</b> Yes 2	
Director	10e. Street and Number				10f. Zip C	Code				10g. Citi	izen of Wh	at Cour	ntry?	
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Be	17. Father's Name (First, Middle, EMORY HARR)						Mother's ! 'HELM		rst, Middle,	Maiden	Sumame)			
ို	19a. Informant's Name/Relations			19h Maille	ng Address (					r City o	or Town Sa	ate 7i-	(Code)	
		S/WIFE			AVIS D								20774	
	20a. Method of Disposition	<u>-,</u>	20b.	Place of Dispo			1	Date		20c. Lo	ocation - Ci	ity or To	own, State	
	1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, crei ARYT AND	•		3/1	17/06	,	CHE	I.TENH	AM.	MARYT.AN	
ġ		4 Donation 5 Other (Specify)  MARYLAND VETERANS 13/17/06 CHELTENHAM, MARYLAND  21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. JENKINS FUNERAL HOME												
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	shock, or heart failur 1/List only one cause on each line.										Approximate Interval Between			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Floretta vernel Hughes 12,2006 March 0216 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner P.G. P.G. Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | M. Worth, 3ay, Year 9 2 8 5. Social Security Number 577-60-0502 7. Age (In yrs. last birthday)
77 yrs. 9. Birthplace (State or Foreign **Funeral** Months Virginia 1 □ M 2 🟋 F Director Usual Residence of Decedent 10b. County P.G. with the Maryland 10a. State Md. 10c. City, Town or Location 10d. Inside City Limits item 27 is marked or higher her insturer, or items 23e or 28a-f show other treumstic event, the Modical Exemples must be notified at Upper Marlboro 1 Xes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9963 Campus Way South 20774 U.S. A. 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other then "naturef", or items 236 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry National Labor Statistical Assistant Elementary/Secondary (0-12) College (1-4or 5+) Relations Board 18. Mother's Name (First, Middle, Maiden Sumame)
Annie E. Cooke 17. Father's Name (First, Middle, Last)
Leonidas E. Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 is marked oth Be Foxx 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 – 19a. Informant's Name/Relationship (Type, Print) Anthony S. Smith- Friend 3630 Austin St. S.E. Washington, D.C. 1244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Olivet 1 Burial 2 Cremation 3 Removal from State Mazsh<sub>6</sub>18, 6 Washington, D.C. Department of importent: if any injury or once. ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Washington, D.C. 20001 Robinson Funeral Home 1313 6th St.N.W. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ateriosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ò in the past 12 months? 1 ☐ Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Asthma 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 1 🗌 Yes 2 🔀 No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐X es 2 ☐ No Certification: To this s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 15, 2006 D0007967 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Riverbend Road Ft. Washington, MD 20744 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2006 Registrar

			1 - State Registrar	State of Ma	aryland		artment of tificate of				jiene eg. No.	J 6	09861
			Decedent's Name (First, Middle, Last)	)	11					Date of Dea	th	Year	3. Time of Death
	Physici /Medio		Elmira	6	Hu	ntle				Month 3	/ 2	- 06	2143 M
1	Examir	er	4a. Facility Name (If not institution, give		1		4b. City, Town,	or Location	of Death		,	ity of Death	1
	Funeral	_	Howard Court  5. Social Security Number 6. Se.	x 7 Age	e (In yrs. las	st birthday)	If Under 1 Yea		r 24 Hrs. 8	B. Date of Birth		9. Birthp	loop (State or Foreign
в	Director		577-40-8014	M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	72	Yrs.	Months Days	Hours	Min. A	(Month, Day pr. 4,	1933	Washi	ington, D.C.
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						Od. Inside City Limits
	Mary I sh	to	Maryland Howard	;	Colum	nbia							1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number				10f. Zip Code			1	l0g. Citizen o	f What Cour	ntry?
	ath wi	rai	8780 Cloudleap Cou				21045				JSA		
	Hems Iner	Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 Ø N		. 13. \	Was Decedent of f Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Speci in, Puerto Ri	ify Yes or No- ican, etc.)		ace - Americ lack, White,	
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••		I□Yes 2XIN	Specify	r:		Spec	ify: Blac	:k
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Medical Exeminer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			(Give	lent's Usual Occi	e durina mo:	st of working	7	16b. Kind of	Business/In	dustry
121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)		conoruse retir			T	rivate	e Home	
0 0	Hygie hygie other		17. Father's Name (First, Middle, Last)			Domes	CIC WOI	,	er's Name (	First, Middle, i			
<u> a</u>	Aental Aental rked tic ev	To Be	Edward Aubrey Broo	ks				Lil1	ian V	irginia	a Harr	is	
Maryland	2 sho		19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Stree	et and Numb	per or Rural i	Route Number	r, City or Tow	n, State, Zip	Code)
e, l	1 and Heelth em 27 ther t		Debra A. DeRosier,	daughter	20h. Pla		Cloudle:	-	The second second second		La, MD 20c. Location		
Jou	ages ant of it: If it y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		сел	netery, cren	natory`or other pi		March 200	15,			Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 Is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Extending roust be notified at ance.	1	21. Signalure of Funeral Service Licens		Ches	apeak	e Crema: .Name and Add ing Home	ress of Facil					
<u> </u>	8858	1 (	Devely & IL	ette		251 Be	verly L	<ul> <li>Heck</li> </ul>	rotte	, P.A.	<u>Clarks</u>	sville	, MD 21029
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused ne cause on each lin	the death. ne.	Oo not ent	er the mode of dy	ring, such as	s cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Arr	47+1	hamia						
	Examiner			Due to (or as a	a conseque	ince of):	150 pa	12					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a conseque	mea of):	(50 pm	7					
	ecuter and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a									
8760,	icate be executed physiclen and s the burial-transit	calE		Due to (or as a	a conseque	rice oi).							
9		B		1.									
30X	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnan	су				Date of delive	ery Day Year
P.O. Box	The law requires thet the death certifi sie hes been signed by the attending sage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 Mo 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	th 5⊡	Other (specify)					ionii i	Day Toal
	s thet t ned by e detai	by Ph	Part II. Other significant conditions con	ntributing to death bu	st not result	ing in the ur	nderlying cause g	iven in Part	l.	23e. Did tol	bacco use co	ntribute to th	ne cause of death?
rds	equires en sign	ed b	****							1 🗆 Ye	es 2□No	3 🗌 Prob	pably 4 mknown
eco	2 8 2	Completed								24a. Was a autops	V	. Were auto	psy findings available mpletion of cause of
<u> </u>	i: The									perform	med? 2 No	death?	
<u> </u>	Physician: Th r this certificete ral director, paç	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No	lospital: 1 ☐ Inpatie		R/Outpatien	20010	than		Check only on			
o	g Physical dispersion	n; To	27. Manner of Death	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury	28c, Inj	4 🗆 1		d. Describe ho			V)
Sior	Attending in death.	catio	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, bu)	, , , , , ,			Yes 2	]No				
Division of Vital Records,	or Attendented of the Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc		ne, farm, str	eet, factory, office	•	28	f. Location (St City or Town		nber or Rura	al Route Number,
	Hospital		29a. Certifier 1 Cartifying Phy	sician: To the best of	of my knowl	edge, death	occurred at the	time, date a	nd place, an	d due to the ca	ause(s) and n	nanner as s	tated.
	I 4 F G	Medical	one)	ner: On the basis of and manner sta	ited.								
	To the within 2 To the complet	2	29b. Signature and title of certifier	King	us. D		29c. Licer	nse number	700	) (	9d. Date sign	ed (Month,	Day, Year)
1	10 (1)		30. Name and address of person who co	ompleted cause of de	eath (Item 2	(Type	Print)	00	300	C 6	5/	14/	06
0	D()		Mark King	57	22	CA	dar L	ane	C	lumbi	a, p	10	21044
	Sta Registr		31. Date filed (Month, Pay, Year) 20	06 32. Registra	ar's Signatu	TA A	29c. Licer						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 Physician Month Year March 12, 10:32 A Lilian June Hooks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9111 Gracious End Court #T-2 Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F 1929 Apr 8, England Director 76 577-44-2186 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Itema 23a or 28a-f ehow 1 ☐ Yes 2 No Maryland Howard Columbia Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9111 Gracious End Court #T-2 21046 United Kingdom e filed within 72 hours after death will Hygiene.

Other than "natural, or Itema 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 00 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:White þ 3 Widowed 4 ☐ Divorced Completed The Mutical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Cosmetology 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth any injury or other traumatic event 9DEs. Lillian Susan Elizabeth Streeter John Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $9045-G\ N.\ Laure1\ Rd.\ Laure1\ MD\ 20723$ 19a, Informant's Name/Relationship (Type, Print) Judy Rhodes/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marchate13. 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State 2006 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Leve 23a. Part1. Enter the Isease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aPancreatic Carcinoma 6 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or se a consequance of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 HInknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 sl performed? res 2 1 No 1 Yes To the Hospital or Attending Physician: After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 13, 2006 D23601 C. 1200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11065 Little Patuxent Pkwy. Columbia, MD 21044 Edward J. Lee, M.D. 31. Date filed (Month, Day, Year) 32. Riegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**MAR 15** 

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylan		artment of			giene	09864
	Physici /Medio		Decedent's Name (First, Middle, Last)     Henry George	e Kogo	k Jr.	,,		2. Date of Dea Month March 10	Day Ye	ar 8:00 P M
	Examir		4a. Facility Name (If not institution, give s. 1722 Peachtree Lane	treet and number)		Bo	or Location of D Wie	eath	4c. County of D Prince Go	
	Funeral Director		5. Social Security Number 6. Sex 216—40—7840 1 ☑ Usual Residence of Decedent	M 2□F 7. Age (In yrs. 63	last birthday) Yrs.	If Under 1 Year Months Day		Hrs. 8. Date of Birth Min. (Month, Day December	14, 1942 9.	Birthplace (State or Foreign Country) Varyland
	Maryland	tor	10a. State 10b. County  Maryland Prince Georg		y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the 23a or 28a	al Director	10e. Street and Number 1722 Peachtree Lane			10f. Zip Code	)721		10g. Citizen of What USA	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Exactinar roual by incilliant and once.	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②☑ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Co	ıban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		omerican Indian, Vhite, etc. White
21215-0036	vithin 72 hounder	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of red)	working	16b. Kind of Busine	ŕ
land 5	ild be filed v lental Hygie kad other t ilc event, ih	To Be Co	17. Father's Name (First, Middle, Last) Henry George Kogok	Sr.	SixCt 1	Etal On	18. Mother's	Name (First, Middle, loria E. Osb	Maiden Sumame)	Etti
Maryland	nd 2 shou alth and M 27 ts mar ir traumat		19a. Informant's Name/Relationship (Type Patricia S. Kogok / Wil					r Rural Route Numbe		e, Zip Code)
Baltimore,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. F	emetery, crer	sition (Name of matory or other p m. Garden		Date 15–06	20c. Location - City Davidsonvill	
Balti	permit. Departn Imports any inju		21. Signatur Pun, ral Service License	θ	22	2. Name and Add	dress of Facility Ons Island	eorge P. Kala Road Edgewa	as Funeral H ter, Marylar	Home PA nd 21037
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	e par		ying, such as car		rest,	Approximate Interval Between Onset and Death
8760,	Examiler and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		uence off:					
P.O. Box 68	ne death certif the attending thed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	fdeath 3	Ectopic pregnar Other (specify)			23d. Date of Month	delivery Day Year
Ś	quires that the signed by ald be detacted		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given în Part I.	23e. Did to	_	e to the cause of death?  Probably 4 Unknown
Vital Record	hysician: The law requir nis certificete has been si I director, page 2 should	Completed						24a. Was a autop perfor	sy prior med? death	e autopsy findings available to completion of cause of n? Yes 2 \sum No
Vita	ician: sertific ector,	Be .	25. Was case referred to medical examiner?	ospital:		10	Thor	Death (Check only or		
ō	nding Phys tth. : After this of tuneral dir	ation; To	1 Yes 2 No  27. Manner of Death  XXXIatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1 28c. In	4 🗀 Nursii	ng Home AAAResid 28d. Describe h	lence 6 Other (5	Specify)
Division	To the Hospital or Attending Phwith 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, offic	ee .	28f. Location (S City or Tow		r Rural Route Number,
	e Hospital	Medical	29a. Certifier XX Certifying Phys (Check only one) 2 ☐ Medical Examin	sician: To the best of my kno ser: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the vestigation, in m	time, date and p y opinion, death o	place, and due to the o occurred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	$\supset$			19655	_	29d. Date signed ( <i>M</i>	
			30. Name and addr s of person who con 3800 Reservoir Ro	mpleted cause of death (Item d., NW Washi		Print) Jo DC 2000	ohn L. M	arshall, M	1.D.	
A. (1)	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 5 2006	37. Registrar's Signa		D				

		1 - For Registrar	State of i	Marylan		artment o			lental Hyg	giene	06	09865
Physic	ian	1. Decedent's Name (First, Middle,							2. Date of Dea Month	ith Day	Year	3. Time of Death
/Med	ical	Fred Carl Krues  4a. Facility Name (If not institution,	<u> </u>	or)		4b. City, Tow	m or Locatio	on of Doath	March		06 nty of Death	3:00 A M
Exami	iner	Dorchester Gene		•		Cambri		on or Death			cheste	r
Funera Director					last birthday) Yrs.	If Under 1 Y	_	der 24 Hrs. rs Min.	8. Date of Birtl (Month, Day Dec. 8,	1926	9. Birthp Cour Mary	place (State or Foreign ntry) Land
ס		Usual Residence of Decedent  10a, State 10b, County			y, Town or Lo	ontion .			bee. o,	1720		10d. Inside City Limits
Maryla 1-f shor	tor	Maryland Dorches	ter		desdal							1 ☐ Yes 2 No
or 28	Directo	10e. Street and Number				10f. Zip Cod	de			10g. Citizen	of What Cour	ntry?
s 23a	ral	4941 Maiden Fore		C 11	6 140		1659	Oriology (Co		US.		1
paritimity (e.) War ylail a LL 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neture!", or Items 23a or 28a-f show eny injury or other treumatic event, the Maryland Examinar manta mailined engines.	by Funeral	11. Marital Status  1  Never Married 2 Marrie  3  Widowed 4  Divorced	12. Was Decede Armed Force 1 XYes 2 If Yes, Give Year or Date	s? 19.		was Decedent f Yes, specify ( 1 ☐ Yes 2 ☒			ecify Yes or No- Rican, etc.)	Spe	Race - Americ Black, White, cify: Wh	
2 hou		15. Decedent's	Education		16a. Dece	dent's Usual O	ccupation	nost of work	ina	16b. Kind of	Business/In	dustry
within 7 noe.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)		kind of work de DO NOT use re h Assis		nost or work	iiig .	Sta	te Hos	nital
filed v Hygie other t	ပိ	11 17. Father's Name (First, Middle, L.	ast)	· · · ·	пеатс	II ASSI		other's Name	e (First, Middle,			pitai
vuld be fill Mental H arked oth	To B	Albert Gustav Kı	rueger					Ida	Rose D	Lskau		
l 2 sho		19a. Informant's Name/Relationshi							al Route Numbe			
1 and 1 and Health tem 27		Lou Ann Truitt/N 20a. Method of Disposition	Niece	20b. P	_	Malden sition (Name of natory or other			d, Rhode		n - City or To	
Pages ent of nt; If i		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp		116		<sub>natory or other</sub> Market		3/16	/2006	East 1	New Ma	rket, MD
Dallillor permit. Pages Department of Importent; If it eny injury or o		21. Signature of uneral Service L	tens e	lee	Ze 10	Name and A Iler Fu 6 Main	ddress of Fa	Home	, P. O. st New N	Box 2	07	
	(	23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that causely one sause on each	sed the deat								Approximate Interval Between Onset and Death
Physician who executed the burial-transit the burial-transit was a control to the burial-transit the burial-	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any back to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseq	oses	alie	Heo	et c	Olse 2 s	2		
e death certific he attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	n 2 ∏ Feta tat time of d	Ideath 3□	Ectopic pregn					Date of delive Month	ery Day Year
iw requires that the speen signed by the should be detach	by	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying cause	e given in Pa	art I.		bacco use co es 2□No		he cause of death? Dably 4 Munknown
vital necol sicien: The law rec s certificate has bee lirector, page 2 shot	Completed	Renal insu	Hicienc	4					24a. Was a autop: perfor	sy .	prior to con death?	ppsy findings available impletion of cause of
ysicien: The last certificate had director, page	Be C	25. Was s referred to medical examiner?					26. PI	ace of Deat	(Check only or			
ng Physic ter this connected dire	2	1 ☐ Yes 2 і No  27. Manner of Death 1 🖟 Natural 5 ☐ Pending	Hospital: 1 Linpi 28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury	28c.	Other: 4   Injury at Work?	-	me 5 Resid 28d. Describe h			ν)
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, to	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of			M eet, factory, off	1 □ Yes 2	-	28f. Location (S City or Tow	treet and Nui n, State)	mber or Rura	al Route Number,
ospital o hours af unerel D y filled ir		29a. Certifier Certifying	Physician: To the be	st of my kno	wledge, death	occurred at th	ne time, date	and place,	and due to the c	ause(s) and	manner as si	tated.
the Hin 24 the Fu	Medical	one)	xaminer: On the basis and manner		uon and/or in							
To To	2	29b. Signature and title of certifier					cense numb			esa. Date sigi	ned (Month,	() (
		30. Name and address of person w	no completed cause of	of death (Item	n 23a) (Type,				359	1		00
		MAhbuba	AKht	er_	300	Hu	101	as	it.Ca	mbr	idge	Md 21613
St Regis	tate trar	31. Date filed (Month, Day, Year)	5 2006 32. Regi	istrar's Signa	iture	bod	,				,	

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

16

2006

			1 - For State Registrar	State of M	arylan	•	artment <i>tificate</i>					giene Reg. No.	1116	09	867
Ţ.,	19 19 14	23	1. Decedent's Name (First, Middle, Las	st)	-						2. Date of Dea Month	ath Day	/ Yes		me of Death
	Physici /Medic		Paul Levy								March 1		2006	- 1	00 P. M
100	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, 1	Town, or	Location of	of Death		4c.	County of D	eath	
	35.		Suburban Hospita		//		Bet If Under	these	la If Under	24 Ыго			Montg		
4	Funeral		5. Social Security Number 6. S	ex ☐M 2☐F 7. Ag	je ( <i>in yr</i> s. i 87	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Mar. 9	v, Year)	19 F	Country) Oland	itate or Foreign
	Director		577-48-2997 Usual Residence of Decedent	Λ	07						IIdi. J	, -,	17 1	- Carrie	
	yland		10a. State 10b. County			y, Town or La									ide City Limits
	B-1-8	ctor	Maryland Montgom	ery	Ro	ckvill	.e							1 (	Yes 2 No
	or 28	Oire	10e. Street and Number				10f. Zip					•	izen of What		
	ath w	Funeral Director	1801 E. Jefferson					0852					S. A.		
	item item	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅	•	.S. 13.	Was Decede f Yes, speci	ent of His rfy Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)		14. Race - A Black, W		an,
36	i', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	140		1 ☐ Yes 2	<b>X</b> No	Specify:				Specify: V	Thite	
ğ	filed within 72 hours atter death with the Maryland Hygiene. other than "natural", or itema 23a or 28a-f show ent, the Mudical Examinational be crotified at	ted	15. Decedent's Ed	lucation			dent's Usual					16b. Ki	ind of Busine		
215		Completed	(Specify only highest gra	de completed) College (1-4or:	5+)	life.	kind of worl DO NOT us	k done di e retired)	uring mos	t ot workit	ng	Ноп	se Pai	intino	and
2	ed will	5	12 Years			Owne	r						Dec	orati	
lud	d oth	Be	17. Father's Name (First, Middle, Last)					1			(First, Middle,	Maiden	Sumame)		Ü
<u> </u>	i Men Marke	ို	Ephraim Lewaszews			401 14 7					msky		T 0: :	7. 0. 1.	
Maryland 21215-0036	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship ( Frederic M. Levy								Route Numbe				
	1 an Heali em 2		20a. Method of Disposition		20b. P	_ lace of Dispo	sition (Nam	e of			ate		ocation - City		
no	Se in age		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State		emetery, cier int Leb				3/13/	2006		lphi,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinat rulal be notified at once.		21. Signature of Funeral Service Licen		riou										
B	Ped ding		Domald (	Storm	-		dward 091 R	ockv	ille	unera Pike	al Dire	vill	e, Mai	yland	20852
dô x			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the teath	h. Do not ent	er the mode	ol dying	, such as	cardiac o	r respiratory ar	rest,		Appro	ximate al Between
	Physician		Immediate Cause (Final disease or condition	Seps										Onse	and Death
for a	/Medical		resulting in death)	Due to (or as		uence of):									
	Examiner		Sequentially list conditions	D		Staph									
	p ji	iner	Sequentially list conditions, if any Isaang Is immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):									
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseni	uence of):								-	
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687	ticate physis the	edical		d											
Вох	The law requires that the death certifics the has been signed by the attending plage 2 should be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			70						23d. Date of	delivery	
Ď.	death e atte d tor	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			]Ectopic pre ] Other (s <i>p</i> e						Month	Day	Year
P.O.	that the de led by the a detached i	hys	9 Unknown	9□ Unknown			× 10				-				
	res tha igned be de	by F	Part II. Other significant conditions of CVA. Tube Feed in				nderlying ca	ause give	n in Part I				ise contribut		
ord	w requir been si should	ted		<u> </u>							1 🗆 Y	∕es 2∑	□No 3□	Probably	4 Unknown
Division of Vital Records,	e law r has be ge 2 sh	Completed	Altered Mental	Status							24a. Was autop	SV	prior	to completio	dings available n of cause of
<u>~</u>	The	S										rmed? 2₩ No	death 1 🗆 Y	i? ′es 2∐ N	0
/ita	ician: ector,	Be	25. Was case referred to medical examiner?	Hospital: X				Otho			(Check only o				
of	Physi this c	2	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 🔁 Inpati		ER/Outpatier 28b. Time of			4 🗀 🕅		ne 5 Resid			pecify)	
CO	ding h. After funer	ion	1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	Bc. Injury Work	ai ? ′es 2 🗍		.od. Describe ii	iow injui	y occurred		
İSİ	Attending Physician: r death. ector: After this certities by the funeral director, I	fica	3 Suicide 6 Could not b		jury - At ho	ome, larm, str					281. Location (S	Street an	d Number or	Rural Route	Number,
2	ai or / after i Dire d in b	Certification:	4 Homicide	building, ei	tc. ( <i>Specit</i> )	y)	,				City or Tow	ın, State	)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely tilled in by the tuneral director, page			ysician: To the best niner: On the basis of											(=)
	the H iin 24 the F	ledical	one)	and manner st						un occurre					
	To You	Σ	29b. Signature and title of certifier	/ .			29c.	License . 621					te signed <i>(Mi</i> cch 11	-	
•	10	20	H. ARL	d IN	0			02.	170			rial	LCII II	, 2000	
	l	177	30. Name and address of person who					ın R	ad	Beth	esda, M	[arv]	Land	20814	
	∜ Sta	to	Dr. Hosseim Al 31. Date filed (Month, Day, Year)						Juu ,	DC C11	- Court	J			
#. X	Registi		31. Date filed (Month, Pay, Year)	2006	180 1	iture	300	,							

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artmen e <i>rtificat</i>			and M	-	giene Reg. No.	Common of the Co	098	68
	Physici	an	Decedent's Name (First, Middle, Last	st)						2. Date of De Month	ath Day	Year	3. Time	of Death
	/Medi		Isabelle Graham		<del></del>					March	12, 20		5:48	рМ
	Examir	ier	4a. Facility Name (If not institution, give	,				Location of	of Death		4c. Cou	nty of Death	1	
4			Union Hospital o  5. Social Security Number 6. S		ounty ge (In yrs. last birthday		ton	If Under:	24 Hrs	9 Date of Pin	Cec		and an inches	
	Funeral Director		218-18-7939	☐M 2MF	89 Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Mar. 6	y, Year) • 1917	Col	y1and	e or Foreign
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation							10d. Inside	City Limite
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or items 23a or 28a-f show other traumatic event, I're Medical Eventrat must be notified at	tor	Maryland Cecil			h East	:							es 2 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cou	untry?	
	th wit	aπ	280 Wheatley Road				2190	)1			Unite	d Stai	tes	
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Deced	dent of H	ispanic Origin, Mexican	gin? (Spe	cify Yes or No Rican, etc.)	- 14. F	Race - Amer Black, White		
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X	No	1 🗆 Yes		Specify:		, , , , , , , ,		city:Whi		
Ö	hour tural	g pe	3XXVidowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	162 Dag	edent's Usua	al Ossue	ation						
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b	al Hyg	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,				
/lai	Menta	70	William C. Graham					Ada	Stew	art				
Maryland	2 should be filed v i and Mental Hygie !s marked other t raumatic event, ID		19a. Informant's Name/Relationship (7	"урө, Print)	- 1					Route Numbe	. ,		. ,	
	Health tem 27 other tra		Dolores McDowell/	laughter	20b. Place of Disp			gh La		d., Che				
Baltimore,	permit. Pages 1 a Depertment of Hea Important: If item any injury or othe once.		20a. Method of Disposition 1 ABurial 2 Cremation 3		cemetery, cre	ematory or o	ther plac		íarch		College	•		a a
Ħ	it. Partitimer ritmer ritmit		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funer: Service is		Rose Bar				2006		Calve:		aryıan	.a
Ba	permit. Pages Depertment of Inportant: If ite sny injury or of		21. Signature of Pullets Service	-						uch Fur North			and 21	001
			23a. Part1. Enter the disease, or comp	dications that caused	the death. Do not er							rial y 1	Approxim	
	Physician /Medical Examiner	r	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Metust Due to (or as	a consequence of):	ustric	Ca	ino					Interval B Onset an	d Death
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Ical Examiner	a any, leading to inmisorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):									
P.O. Box 68	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pr						Date of deliv	very Day	Year
	es tha gned be de	þ	Part II. Dther significant conditions o	ontributing to death b	ut not resulting in the	underlying c	ause give	en in Part I.		23e. Did to	obacco use c	-	the cause of	
Vital Records,	v requir been si should	Completed												
Rec	0 - 0	mp								24a. Was autop	an 24 sy rmed2	prior to co death?	opsy finding ompletion of	cause of
E	an: Th rtificate tor, pag	ပိ	25. Was case referred to medical					00 81	-( 5	1 ☐ Yes	2 No	1 🗆 Yes	2 No	
	Physician: r this certific ral director,	0 8	examiner?	Hospital:	ent 2 ☐ ER/Outpatie	ent 3 DC	Othe	er.		(Check only one 5 ☐ Resid		Othor (Coo	:4.1	
O	g Phy er thii	n: T	27. Manne eath	28a. Date of Inju (Month, Da			8c. Injury Work			8d. Describe h			iry)	
<u> </u>	Attending or death.	atlo	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury	М		Yes 2 1	V0					
Division	i gite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	ury - At home, farm, si c. (Specify)	treet, factory	r, office		2	8f. Location (S City or Tox	Street and Nu vn, State)	mber or Rui	ral Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis o and manner sto	of my knowledge, dea f examination and/or in ateg.	th occurred nvestigation	at the tim	e, date and pinion, deat	d place, a th occurre	nd due to the old at the time,	cause(s) and date and plac	manner as	stated. to the cause	n(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	// /	1.1	_		number			29d. Date sig	ned (Month,	Day, Year)	
			\[ \frac{\gamma/\lambda}{\lambda} \]	19W/1	M	I	35	5000	3		3/15	106		
	11		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	, Print)					1'	1	, ————	
	4		Dr. Martha	HOSF	odill	wh	Pil	n 5	IT, E	STOTE	M. M	ID	310	161
	Sta Registr		31. Date filed (Month, Day, Year)	6 2006 > 2	ar's Signature	Ane	de)				-			

	1	For State Registrar	State of Man			nt of He te of D			giene Rag. No.	005	09869
Physicia	_	I. Decedent's Name (First, Middle, L.						2. Date of De Month	Day		3. Time of Death
/Medica Examine	al -	EDWARD FRAN  a. Facility Name (If not institution, gi  CARROLL HOSPITA	ve street and number)	AY			ocation of Deat	MARCH	13 4c.	3 200 County of Dear CARR	th
uneral			Sex 7. Age (/	In yrs. last birthday) 39 Yrs.	If Unde Months		f Under 24 Hrs Hours Min		th ly, Year) 196	9. Bin Co M	thplace (State or Foreign ountry) aryland
		Jsual Residence of Decedent 10a. State 10b. County Md. Monto	omery	Oc. City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 SNo
Importent: If item 27 is marked other than "naturel; or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner mant be notified at once.	Director	10e. Street and Number 9863 Main Stree		Danaso		p Code	20872		•	zen of What Co	-
antiner must	<u>a</u>	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 元 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1  Yes		panic Origin? (S Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ame Black, Whit Specify:	erican Indian,
e Medical Ex	Completed b	15. Decedent's (Specify only highest g	ducation	(Give	kind of w DO NOT	ual Occupat ork done de use retired) ck Dri	ring most of wo	nrking		nd of Business	
ic event, in	To Be Co	12 17. Father's Name (First, Middle, Las William H. Mo						me (First, Middle	, Maiden rrow	Sumame)	
treumat		19a. Informant's Name/Relationship Beverly M. McKa		19b. Maili 1012	ng Addres 8 Ric	ss (Street ar dgelir	d Number or A	ural Route Numb e, Montgo:	er, City o mery	r Town, State, Villag	Zip Code) e,Md. 20886
		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec		20b. Place of Disponentery, cre All Soul	matory or	other place	) _	Date /20/06		cation - City or rmantow	
any inlur		21. Signature of Funeral Service Lic		They	Mu	and Address	. Barb	er Funer 3, Layto	al H	ome	. 20882
ian cal		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the yone cause on each line.  a. Ex Sang  Due to (or as a company)	unation	ter the mo	ode of dying	such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
<u>ā</u>	cal Exa	Ecquentially list our dilicit.  fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence of):	o Cov	cino	ne, of	ston	ach		
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ld be deta	<u> </u>	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying	cause give	in Part I.	1	tobacco		to the cause of death?  robably 4 Unknown
S CA	Completed							24a. Was auto peri 1 🗆 Yes	opsy ormed?	prior to death?	
s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Alnpatient	2 ER/Outpatie	nt 3 🗆 0	Othe	-	eath <i>(Check only</i> Home 5  Res		6 ☐Other (Sp	ecify)
r: After thi e funeral (		27. Manner of Death  1 🔊 Natural 5 🗌 Pending 2 🗋 Accident investigat	28a. Date of Injury (Month, Day)	Year) 28b. Time (Injury	of M	28c. Injury Work 1 🗆 Y	at ? es 2 ⊡No	28d. Describe	how inju	ry occurred	
al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injur- building, etc.	y - At home, farm, s (Specify)	reet, facto	ory, office		28f. Location City or To			Rural Route Number,
within 44 rous ener usent.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai (	29a. Certifier 12 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of e and manner state	xamination and/or i	th occurre	ed at the tim on, in my op	e, date and pla inion, death oc	ce, and due to the curred at the time	e cause(s , date an	) and manner a d place, and du	es stated. e to the cause(s)
To th	Σ	29b. Signature and title of certifier	1			9c. License				ite signed (Mor	-
		30. Name and address of person wh		ath (Item 23a) (Type Washing)	, Print)	115	4939	-( ()	3	114/20	er, MD 21157
		B. Imanuel,	DO: 218								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year Month **Physician** Emerita Rosales March 13, Martin 4:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or I) | Aug. 24, 1933 | Philippines 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2☐F 729-03-9586 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene Importment: If itam 27 is marked other then "natural", or items 23a or 28a-f show enty industry or other traumatic event, the Medical Examinat must be notified at one. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2√ No Director Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14107 Angelton Terrace 20866 by Funeral Philippines 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify: Asian 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pedro Rosales Asuncion L. Liwaq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristina M. Tafalla/Daughter 14107 Angelton Terrace, Burtonsville, MD 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 21 San Miguel Bulacan, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State San Miguel Catholic Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Philippines 21. Signature of Funeral Service Licensee Francis Adress Collins Funeral Home Inc. Kein Skile 500 University Blvd, W, Silver Spring, MD 20901 23a. 1-11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner Acute Pyelonephritis Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (ur as a consequence of) Examine the attending physicien and hed for use as the burial-transit death certificate be executed Hydronephrosis Due to (or as a consequence of). P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Type II Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificete has autopsy 2 No 1□ Yes Division of Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 No Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours after within 24 hours at To the Funerel D completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/13/2006 DR63579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tayag, 1500 Forest Glen Road, Silver Spring, MD 20910 M.D. 31. Date filed (Month, Day, WAR 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

6 2006

			1 - For State Registrar	State of	Marylan		artment rtificate				lental F	lygie Reg.	a UI	) 5	09	871
	Physici		1. Decedent's Name (First, Middle, Lambert Muller-T	,							2. Date of Month March		Day 2006	Year		of Death 10 ам
	/Medi Examir		4a. Facility Name (If not institution, gi	ve street and numi					Location o	of Death	1142 011		4c. County	of Death		
	Funeral				. Age (In yrs.		If Under Months		Grac If Under Hours		8. Date of (Month),	Rinth		9. Birthp	olace (State	e or Foreign
	Director		180-24-1537  Usual Residence of Decedent  10a. State 10b. County		83	Yrs. y, Town or Lo					4/3/	1922			sý1va	
Ź	r 28a-f show	ctor	Maryland Cecil			ryvill										City Limits
T	th with the 23a or 21	ai Dire	10e. Street and Number 172 Muller-Thym F	arm Lane			10f. Zip						Citizen of V		•	
-089e	hours after death with the Maryland turel', or items 23a or 28a-f show al Examiner must be notified	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Force fy XYes 2 If Yes, Give Year or Dat	es? □ No 194:	3-	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or Rican, etc.)	No-	Blad	e-Americk, White,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mudical Examinat must once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4		16a. Deced (Give life.	dent's Usua kind of won DO NOT us	k done d e retired,	turing mosi )	t of worki	ng		Kind of B		dustry	
$\sqrt{2}$ $\sqrt{6}$	buid be filed Mental Hygin arked other atic event, I	To Be Co	12 17. Father's Name (First, Middle, Las. Harold Muller-Th			Own	er/Op				(First, Midd	lle, Maid	den Suman	10)		
/ / ~ / / , Maryl	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship Patricia Heaps/da								Noute Num				Code)	
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Vital R	Physician: this certific ral director,	To Be (	25. Was case referred to medical examiner?	Hospital:	patient 2 □ 1	ER/Outpatien	t 3 DOA	Othe	_		(Check only	one)				
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	ne Hospital n 24 hours e ne Funeral l	Medical	29a. Certifier 1 Certifying PI (Check only one) 2 Medical Exact	nysician: To the be miner: On the bas and manne	is of examinat	wledge, death ion and/or inv	occurred a restigation,	t the timi	e, date and inion, deat	d place, a	and due to the	e cause e, date	(s) and ma and place, a	nner as st and due to	ated. the cause	•(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	50					number	22			Date signed			
2	0-1VA		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I	Print) A	ve	L	tavi	e D	e (.	TAR	o N	1.D =	2/078
(X)	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2006	32. Reg	istrar's Signat	Local				-i P			100			

BERT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gordon Dietrich Mayers 9:10 A M 14 March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⋈**M 2□F 86 215-01-2509 Director **Yrs** 20, 1919 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Anne Arundel Annapolis Maryland Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1959 Marconi Circle 21401 U.S.A. death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal. Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumming. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2X No White ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allen Mayers Cora Edna Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 382 Forest Beach Road Annapolis, Maryland Gordon Mayers, Jr./son 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/17/2006 Holy-Cross Cemetery Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Junera Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) 7001 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Examiner burial-transit o the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, the the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day 4□Pregnant at time of death signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۴ 1 opatient 2 ER/Outpatient 3□ DOA this After thi 28b. Time of Injury 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physicien: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29b. Signature and title of centifier, 29d. Date signed (Month, Day, Year) 024804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway rete 200017 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 5 Registrar 2006

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#4a.& 26.PerPhys.PCC 3-17-06 Gertificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month Year **Physician** THELMA R. NORRIS March 13, 6:45 a M /Medical 4a. Facility Name (If cot institution give street and number)
Shant I HME Attituded to 6410 Old Sandy Spring Road 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Laure1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕅 F Director 87 216-09-0720 June 25, 1918 Virginia Usual Residence of Decedent daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits : if item 27 is marked other then "naturel", or iteme 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at 10b. County 1▼ Yes 2 No Funeral Directo Maryland Prince George's College Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5003 Erie Street U.S.A.

14. Race - American Indian, 20740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Bookkeeper Local Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F is marked of Be Newton Randolph Mary Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 lt Eunice E. Long - Sister 50th Avenue, College Park, Maryland 20740

(Name of Date 20c. Location - City or Town, State 9503 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/18/2006 Brentwood, Maryland permit. Pag Department Important: I any injury o Fort Lincoln Cemetery 4 □Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Maryland 20781 Tullelle 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACOTE MYOCARDIA L INFARCTION
Due to (or as a consequence of): 3-13-06 disease or condition resulting in death) /Medical Examiner HEART DISEASE THERO SCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and tor use as the burial-transit law requires that the death certiticate be executed LZHEIMER Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 28 No 1 ☐ Yes neral Director: After this certific tilled in by the tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 X Other (Specify) Assisted Liv ۵ 1 ¥ Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Elphusen M Do013668 March 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azher Hussain, MD 4719 Edgewood Road, College Park, Maryland 20740 32. Registrar's Signature MAR 1 6 Z006 State Registrar

		1 - For State Registrar	State	of Marylan				lealth a D <i>eath</i>	nd M		giene Reg. No	UUb	09876
		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath Da	v Year	3. Time of Death
Physic /Med		Richard Lee Po	unsberry	, Sr.						March 2	25,	2006	7:00 P M
Exam		4a. Fecility Name (If not institution	-					Location of				. County of Death	_
		17308 Clagett					pper or 1 Year	Marlb		8. Date of Birt		rince Ge	
Funera		5. Social Security Number	6. Sex 1 <b>∑</b> M 2 ☐ F	7. Age (In yrs.	74 Yrs.	Months		Hours	Min.	(Month, Da	y. Year		place (State or Foreign intry) Stville, MD
Directo		220-28-6195 Usual Residence of Decedent			/4				[	Sept. 1	,	931 Fore	stville, MD
yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
a-fel	to	Maryland Princ	e George	's	U	pper	Marl	boro					1  Yes 2  No
or 28	Director	10e. Street and Number				10f. Z	p Code	4			-	tizen of What Cou	intry?
ath w	rai	17308 Clagett					2077		. 0 (0			USA	
er de	Funerai	11. Marital Status	Armed	cedent Ever in U Forces?	l.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Orig ın, Mexican,	in? (Spe Puerto I	cify Yes or No Rican, etc.)		14. Race - Amer Black, White	
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2 hou	ed	15. Deceder	I's Education		16a. Dece	dent's Us	al Occup	ation	-6 -40		16b. K	Kind of Business/li	ndustry
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12 sh and 10 m		19a. Informant's Name/Relations				•					-	or Town, State, Zi	o, MD 20774
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other traumatic ev		19a. Informant's Name/Relationship				Street and Numb				, State, Zip	Code)	
per t		Delores W. Pric	e (Wife			Terrace	A STATE OF	eaton, M				
5	- 5	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Star	te cemetery,	isposition (Name crematory or oth	e of ner place)	U	ate 2	0c. Location	- City or To	wn, State	
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	Physici /Medic		Decedent's Name (First, Middle, Last)     Agnes     Popovc	zak		2. Date of March	n 10, 200	3. Time of Dealth 12:30Р.м
,	Examir		4a. Facility Nam <i>e (If not institution, give street and number)</i> 13022 Blairmore Street		4b. City, Town, or Loc Beltsvi		4c. County of Princ	Death e George's
	Funeral Director		097-05-8128 1□M 2X7F	e (In yrs. last birthday) 90 Yrs.		Junder 24 Hrs. 8. Date of the burs Min. 9. June 2	f Birth (29,1791) 5	9. Birthplace (State or Foreign Country) New York
	Maryland If show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince George's	10c. City, Town or Lo Beltsvil				10d. Inside City Limits 1 Tyes 2 No
	th with the 23a or 28a ist be noti	Funeral Director	13022 Blairmore Street		10f. Zip Code 20705		10g. Citizen of Wh United	at Country? States
036	within 72 hours after death with the Maryland jiene. itene." Internation of Iten was a contained at the Macilcal Examiner must be notified at the Macilcal Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:	10	f Yes, specify Cuban, M	nic Origin? (Specify Yes o exican, Puerto Rican, etc. pecify:		American Indian, White, etc. White
-5121	vithin 72 ne. hen "ne e Madic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) ekeeper	g most of working	16b. Kind of Busi	
land	ild be filed lental Hygid ked other ic event, II	To Be C	17. Father's Name (First, Middle, Last) Alexander Cudn	ik		Mother's Name (First, Mid ary	<sup>ddle, Maiden Sumame)</sup> Zalen	ska
Mary	od 2 shou Ith and M 27 Is mar treumet		19a. Informant's Name/Relationship (Type, Print) Helen E. Andreno -daughter	19b. Mailir 13022	g Address (Street and A Blairmore	Number or Rural Route Nu Street Belts	umber, City or Town, St Sville, Mar	ate, Zip Code) yland 20705
Baltimore,	permit. Pagoss 1 and 2 should be illed v Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury or other treumetic event, III once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, crem Metropol:	natory or other place)	ory 3/12/200	20c. Location - Ci	ty or Town, State ia, Virginia
Balt	permit. Departri Imports any inju		21. Signature of Funeral Service Licensee  Localel U, Bayer  23a. Part1. Enter the disease, or complications that caused	44	400 Powder		eltsville,	PA Maryland 2070
	Iteate be executed / Medical be be executed / Medical but and but at the parial-transit sthe parial-transit street was the par	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of): a consequence of):	NSION	ardiovasu	La Dise	ase I weel
BOX 6	death certii e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date (	
7	9 P	by	Part II. Dther significant conditions contributing to death by Diabetes MeU	ut not resulting in the u	nderlying cause given in			ute to the cause of death?
ř	The ate h	Completed				a	utopsy prid erformed? dea	re autopsy findings available or to completion of cause of ath?
VII	certific rector,	Be	25. Was case referred to medical examiner?		Other	Place of Death (Check or		
on or	After After funer	ation: To	1 Yes 2 No 1 Inpatie  27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	y 28b. Time of	28c. Injury at Work?  M 1 \( \text{Yes} \)		Residence 6 Other ibe how injury occurred	
Division	To the Hospitel or Attant within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injuding, etc.	ury - At home, farm, street. (Specify)	eet, factory, office		on (Street and Number Town, State)	or Rural Route Number,
	o Hospitel or no 24 hours afte or no Eunerel Dire Funerel Dire bletely filled in h	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner sta	examination and/or inv	occurred at the time, dovestigation, in my opinion	ate and place, and due to n, death occurred at the ti	the cause(s) and mann me, date and place, and	er as stated. d due to the cause(s)
,		Me	29b. Signature and title of certifier		29c. License nun		29d. Date signed (1	Month, Day, Year)
	3		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	el Park D	rive Ste	214 La	0/06 2070 wel. HO
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra MAR 1 6 2006	ar's Signature	ules			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death <sup>Day</sup> 2<u>006</u> **Physician** March 12, 2:26 A. M Sidney Myer Plitman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7425 Democracy Blvd., # 112 Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Jan. 12, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1₩ 2□F Hours 83 Yrs. 1923 Wash. D. C. 578-24-8965 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State injury of other freumatic event, the Madical Examinational Le notified at 1. Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7425 Democracy Blvd., # 112 20817 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ¥es 2 □ No Army If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Years General Manager Automobile 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental h Plitman Mayme Snitz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m 7425 Democracy Blvd., Neva J. Plitman - Wife # 112, Bethesda, Md. 20817 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State King David Mem. Gdns. 3/14/2006 Falls Church, Va. 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. any ir 1170 Rockville Pike, Rockville, Maryland 20852 First Enterthe arease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Cancer of Colon Months disease or condition resulting in death) /Medical Due to (or as a consequence of) End Stage Renal Disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2X No ģ 5 Other (specify) 4□Pregnant at time of death 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗀 Yes 2 XNo After this funeral d 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No investigation 2 Accident after death | Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Within 24 hours are.
To the Funerel Directors of the Funerel Directors Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059137 March 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kelly Cowen 1201 Seven Locks Road, Rockville, Maryland 20854 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 16 2006 September 1

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Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			giene () () ()	09880
	Dhysisi	22	1. Decedent's Name (First, Middle, Last)				·	2. Date of Dea Month	ath Day Year	3. Time of Death
	Physici /Medio		Barbara May Padd	У				March '	12, 2006	3:30 A M
1	Examir	er	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Deatl	
	~		Anne Arundel Medic			Annapol If Under 1 Year	If Under 24 Hrs.	T	Anne Ar	
н	Funeral Director		5. Social Security Number 6. Sex 1□		(In yrs. last birthday) 67 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 6-3-19		nplace (State or Foreign untry)
			Usual Residence of Decedent		07			0-3-13.	was was	hington,DC
	yland yland		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	a-f si	ctor	Maryland Anne Aru	ndel	Edgev	ater				1 ☐ Yes 2 🛣 No
	ith the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	ath w	ral	1706 Ridgely Rd.,			21037			USA	
9	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disal Examination was be undiffied at	by Funeral	1 Never Married 2 Married	<ol> <li>Was Decedent E- Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give</li> </ol>		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
Ş	72 hours "natural", edical Ex	q pe	3 X Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16a Daga	dont's Haval Ossuna	ition		16b. Kind of Business/I	
9500-6121	I within 72 ho iene. r than "natur the Medical	Completed	(Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing	TOD. KING OF BUSINESSY	ndustry
7.	filed within Hygiene. Ither than "	шо	Elementary/Secondary (0-12) 12th	College (1-4or 5+		rtender			Hospita	lity
2	filed Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yland	ould be Mental arked o	To B	Archie Willi	am Coulte	r		Myr	tle Ire	ne Lowe	
Mary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Typ	оө, Print)					r, City or Town, State, Z	ip Code)
			Marvin K. Paddy/ S	on		). Box 571				
o G	S - = 0		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, crea	sition (Name of matory or other place	9)	Date	20c. Location - City or	Town, State
	Pag tment tant:		4 □Donation 5 □Other (Specify)			Crematory	3–14		Edgewater,	
Baltimore,	permit. Page Department of Important: If any injury or once.	, 5	21. Signatura Funeral Service License	98					Kalas Fune dgewater, M	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused t e cause on each line	he death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		SIABE	1ES				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	ENSIG				
	- Adminion	<b>L</b>	Sequentially list conditions,	Due to (or as a	consequence of):	80319				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 45 4	35/135 <b>43</b> 3/135 3/).					
,	execun and ial-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
58/60,	ificate be executed physician and st the burial-transit	edical	<b>U</b> ₀							
S O	= O mi	Aedl	IF FEMALE.							
X Q Q	death certifi e attending d for use as	an/N	23b. was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy			23d. Date of deliment	•
	the dea by the at ached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death 5	Other (specify)			Month	Day Year
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ecora	v requ	ete						24a. Was a	24h Were aut	opsy findings available
ě	e lav has	Completed						autop: perfor	sy prior to c med? death?	ompletion of cause of
	ilcian: Thi certificate rector, pag	C	25. Was case referred to medical				26. Place of Death		22No 1 Yes	2 ∐ No
5	Physician: r this certific ral director,	0 8	examiner?	ospital:	t 2 ER/Outpatier	nt 3□ DOA Othe	r		ence 6 Other (Spec	ifv)
<u></u>	iding Physician: th. : After this certifics funeral director, f	n; T	27. Manner of Ceath	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	at		ow injury occurred	.,
0	endir sath. or: Af he fur	atlc	1 Natural 5 Pending 2 Accident investigation	(	,,		es 2 □ No			
DIVISION	or Att after de Directi in by t	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
_	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funera	edical Co	29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, deatl	n occurred at the time	e, date and place,	and due to the c	ause(s) and manner as date and place, and due	stated.
	the hin 24 the F	Medi	onej	and manner state	ed.				29d. Date signed (Manth	
)	70 Wit	-	29b. Signature and title of certifier	~ P		29c. License	3,2	1	2/12/	4/
			20 Name and address of access with an	mpleted sauss of day	ath (Item 22a) (Time	Print)	0, 3		7[12]	70
			30. Name and address of person who col	32. Registrar	327 CI	NDEN	AVE	13MI1	MORE N	10 21201
	Sta Registr	- 1	MAR 1 5 2008		B Ace	all .				

ORIGINAL

Registrar

			1 For	State of Ma	aryland.	•	ment of H		d Mental Hy	0.0	T 0 1	00002	
		_	Registrar  1. Decedent's Name (First, Middle, Li	ant)		Cerui	ilcale of L	Jeani	2. Date of De	Reg. No.	1110	3. Time of Death	
	Physici	an		,	7				Month .	Day	Year		
-	/Medic	ai	Tyrone Wil		lmer		- 0'h T	Lastin (D	MARCH	14	2066	1036 M	_
1	Examir	er	4a. Facility Name (If not institution, gi	ve street and number)		4	b. City, Town, or	Location of Di	eath	40.0	County of Death		
			Peninsula Regio	m/ Medica	21 CM	Her	f Under 1 Year	Sbury If Under 24 F	Hrs la Data at Di	<i>\</i>	VICANIC	0	_
	Funeral			A SOL	ə (İn yrs. last		Months Days		Min. 8. Date of Bir (Month, Da Jan. 5	Year)	Cour	place (State or Foreign htry) York	
	Director		212-48-3061 Usual Residence of Decedent	5	7				Jan. 5	134	new	YOLK	_
	and and		10a. State 10b. County		10c. City, T	Town or Locat	tion				1	0d. Inside City Limits	-
	Aary ehc	ō	Maryland Wico	mico	Sa	alisbu	1 <b>~</b> 37					1 X Yes 2 ☐ No	
	28a-	Directo	10e. Street and Number				10f. Zip Code			10a Citiza	en of What Cour	atry?	-
	with a or	급										iti y :	
	s 23	Funeral	411 Rose Stre	12. Was Decedent I	Ever in II S	12 14/2		21801	2 (Specify Ves or No		S.A 4. Race - Americ	an Indian	
	er de	ů	11. Maritat Status	Armed Forces?		tf Y	es, specify Cuba	n, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	,-	Black, White,		
36	s aff	by F	1 Never Married  Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	9/7-7	7/ 10	Yes 2 No	Specify:			Specify: Dla	a ale	
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f ehow deal Examiner must be motified at	pa	15. Decedent's E				it's Usual Occupa	ation		16h Kin	Bla d of Business/In		-
15	n 72	Completed	(Specify only highest g			(Give kin	d of work done o	during most of	working	100. 1411	a or Daginosa in	destry	
12	withi Bne. than	m d	Elementary/Secondary (0-12)	College (1-4or 5	+)	Labo		,		No	one		
2	filed within Hygiene. other then "		17. Father's Name (First, Middle, Las	t)		Labe	71 01	18. Mother's	Name (First, Middle	l			-
an.	Mental Mental arked o	Be	James Palmer	,							,		
Ē	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship	(Type Print)		10h Mailing	Address (Street		nown r Rural Route Numb	or Cityon	Town State Zin	Code	_
Maryland	12 sho h and 7 ts ma rauma	8				•						0.0000/	
	t and tealth om 27 than tr	1 3	Jessica Palmer	(Wile)					bury, Md.		ation - City or To	Ctate and	_
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow my injury or other traumatic event, its Medical Examiner must be collified at 2008.		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3	☐Removal from State	cem	etery, cremat	on (Name of ory or other plac	e)	Date	200. L00	ation - City of To	OWIT, State	
Ë	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Spec		Sali	sbury	/ Crema	tory 3	-21-2006	Sali	sbury,	Md.	
ä	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	nsee	-4-	22. N S t	lame and Addres	Funer.	al Home alisbury				
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			23a. Part1. Enter the disease, or cor shock, or heart allure. List only	nplications that caused one cause on each lin	the death. (							Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	mitter	Jales	luna	Chara	noma	_			Onset and Death	
1	/Medical		resulting in death)	Due to (or as	a consequen	nce of):	1	710713					_
ш	Examiner		ANALYSI DOMONO ONOCATRI INVOICE			ŕ	V						
		ē	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	nce of):							_
	uted	표	Cause (Disease or injury that initiated events										
,	be executed sicien and burial-transit	Examiner	resulting in death) Last	c. Due to (or as	a consequen	nce of);							
8760,	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit			d									
687	icate phys s the	Physician/Medical		d									
×	leath certifica ettending ph for use as t	×	IF FEMALE:	23c. If yes, outcome	of pregnancy	v				2:	3d. Date of delive	erv	
Вох	eath etter for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3⊟Eo	topic pregnancy				Month	Day Year	
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Will or Godin	526	(10) (0)0011)						
P.0	that the de ted by the e detached f		Part II. Other significent conditions	contributing to death b	ut not resultir	ng in the unde	erlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	he cause of death?	_
of Vital Records,	ires thai signed I d be det	þ	ale dete	A	mmo	ed.	(Ada		10	Yes 2□	No 3□ Prob	pably 4 Honknown	
5	v require been sig should t	Completed	- Civoria de la	1	. ) .	A			-	1		,	
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<u> </u>	The ate h	Ş	Mystersion	١ ر					1 ☐ Yes	ormed? 2 ₩o	death?	2 □ No	
ita	Physician: Th this certificate ral director, pag	Be (	25. Was case e rred to medical examiner?					26. Place of	Death (Check only	one)			_
>	Physic this ce al dire	To	1 Yes 2 No	Hospital: 1 Umpatie	nt 2 ER	VOutpatient	3□ DOA Othe	er: 4 🗌 Nursin	ng Home 5 Resi	idence 6	Other (Specif	(y)	
	ding Ph h. After th funeral	Ë	27. Manner of Death	28a. Date of Inju (Month, Da)	ry 28	3b. Time of Injury	28c. Injun Worl	/ at	28d. Describe	how injury	occurred		
<u>ō</u>	Attending or death. actor: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		, , , ,	,,		Yes 2 No					
Division	Atte	100	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of Inju		e, farm, street	t, factory, office		28f. Location (	Street and wn, State)	Number or Rura	al Route Number,	
Ö	s effe il Dir id in	Certification:		building, etc	o. (Spacity)				City Gi 10	, Jiaid)			
	To the Hospital or Attending Physician: The within 24 hours elier death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying F	hysician: To the best	of my knowle	edge, death o	ccurred at the tin	ne, date and pl	lace, and due to the	cause(s) a	and manner as s	tated.	-
	P Hc P 24   P Fu letely	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination	n and/or inves	stigation, in my o	pinion, death o	occurred at the time,	date and	place, and due to	o the cause(s)	
	of thir	₹ E	29b. Signal and title of certifier	1			29c. License	e number			signed (Month,		Ī
	- > - 0		1 Colores	allem	rch.	m. D	DI:	5384			MARCH, 1	4,2006	
	II MAY		30. Name and address of person vin	completed sause of d	eath (Itam 3	3a) (Type Pri	int)		1				_
	1 Wil		D. A. L. A. W.		346	S. Nivi	IICIANI C	5T. C	BALISBU	RY 1	nD 218	204	
	Sta	10	31. Date filed (Month, Day, Year)		ar's Signatur	θ,	1310/	-1.		(			-
	Regist		MAR 1 6		WAR A	or do	ares						

1213-48.3061

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** March 15,2006 10:40a <sup>™</sup> Luz Maria Rosario /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 Cours | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) Puerto 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**]** ₹ F 71 Yrs. April 26,1934 582-52-8978 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits rthen "natural", or Items 23s or 28s-f show the Medical Exeminar over the notified at Yes 2 No Completed by Funeral Director MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 U.S.A. 1 Maple Court filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 √Yes 2 □ No Specify. 3 ☐ Widowed 4 ☐ Divorced Puerto Ricah Hispanic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked of Santos Rosario ပ Pauale Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 456 Willow Drive, Elkton, MD 21921
Date 20c. Location City or Town, State nt of Health a t: If item 27 la r or other tree John Diaz/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Immaculate Conception March permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD R.C. Cometter VAddress of Facility ice Licensee Andrew G. GeeFuneral Home 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unk /Medical Due to (or as a consequence of) Examiner Unk Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physicien and s the burial-transit The law requires that the death certificate be executed unk PICTON (or s consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical as esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Day 4☐Pregnant at time of death signed by the all d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 2 12 No or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00060756 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) saugonimu FIKKO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary		tificate of			Reg. No.	6 11988
Physic	oian	1. Decedent's Name (First, Middle, Last)					2. Dete of De Month	Day	3. Time of Dea
Physi /Med		KATHERINE STEELE						9, 2006	5:45 a
Exam		4a Fecility Name (If not institution, give	street end number)			4b. City, Town, or	Location of Death		
	0	Prince George's N			W.11	Chever1y			e George's
Funera Directo		5. Social Security Number  413-54-7385  Usuel Residence of Decedent	-74	yrs. lest birthday) 73 Yrs.	If Under 1 Year Months Days	Hours Min.		th y, Year) 1932	9. Birthplace (State or Fo Country) Mississippi
aryland show	<b>~</b>	10a. State 10b. County		c. City, Town or Lo	cetion				10d. Inside City L 1 X Yes 2 E
Ne M	Director	Maryland Prince Ge	eorge's	Cheverly	1401 71 0 1			10g. Citizen of W	
with the		10e. Street end Number			10f. Zip Code				net Country?
e 23	era	3035 Hospital Dr	IVE 12. Was Decedent Ever	in 11 S   12 1	2078		necify Ves or No	U.S.A.	- American Indian,
d 21215-UU2U filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Exercise must be notified at	y Funeral	11. Maritel Status  1 ☒ Never Married 2 ☐ Merried  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	to Rican, etc.)	Black Specify:	White, etc. Black
2 hou	Completed by	15. Decedent's Educ		16a. Deced	ent's Usuel Occup	pation		16b. Kind of Bus	siness/Industry
Maryland 21215-0020 d 2 should be filed within 72 hours aff th end Mental Hygiene. 77 la marked other than "natural", or traumatic event, the Medical Exert traumatic event, the Medical Exert	per	(Specify only highest grede Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most of word)	rking		
Z1Z d with giene. r ther	E	unavailable	00110g0 (1 401 51)	Beau	tician			Private	
	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Surname	a)
aryian should be nd Mental marked o	To	Unknown				Unknowr	1		
2 sho end a me	12	19a. Informant's Name/Relationship (Type	pe, Print)	1000		and Number or Ru			
end end n 27		Claudia John - G							ryland 20748
ore of H	- 9	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20 Jemoval from State	<ol> <li>Place of Dispo cemetery, cren</li> </ol>	sition (Name of natory or other pla		Date		City or Town, State
Pag nant ant: r		4 Donation 5 Other (Specify)	amovar nom state	Fort Linco					od, Maryland
baltimore, Marylar permit. Pages 1 end 2 should be Depertment of Health end Menta Important: If then 27 la marked eny Injury or other traumatic e		21. Signature of Funeral Service License	90						ome, P.A. MD 20781
		23a. Part1. Enter the diseese, or complishock, or heart failure. List only on	cations thet caused the re cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Betwee Onset and Dea
Physiciar /Medica		Immediate Cause (Final							
Examine		disease or condition resulting in death)	End Stage						1 Year
	9		Due	to (or as a conseq	uence of):				1
uted	edical Examiner	0	)	to (or as e conseq	uence of):				
exec n en ial-tra	Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	200	to (or as a conseq	derice or).				
<b>56 / 50,</b> tificete be executed g physician end es the burial-transit	Cal	that initiated events	Due Due	to (or as a conseq	uence of):				
death certificete be executed teath certificate be executed eathending physician end ed for use as the bunal-transit	8	resulting in death) Last		(0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0					
IS, F.O. BOX es that the death cert igned by the attendin be detached for use	Physician/M	d	1						
deat deat	SCia	Part II. Other significant conditions con	tributing to death but no	t resulting in the ur	iderlying cause giv	en in Part I.	23b. Did 1	tobecco use con	tribute to the cause of d
that the detached	ڇَ	Dhawara da Amehan	itia. Domon	tion Coh	izanhran	iot	10	Yes 2 No	3 ☐ Probably 4 ☐ Uni
as that	þ	Rheumatoid Arthr	itis, Demen	icia, scii	izopiii eii.	<u></u>			
requir	Completed	Anemia; Thromboc	ytosis; Gra	nylocyto	sis		24a. Was perfo	an autopsy rmed?	24b. Were autopsy findi available prior to completion of caus of death?
The law cate has I	ĕ						101	Ves 2Xttc	1 ☐ Yes 2 ☐ No
VICAL I	Be	25. Was case referred to medical examiner?					ath (Check only o	one)	
OI VILO Physician: this certific ral director,	10	1 □ Yes 21ሺ No		2 ER/Outpatien	3 DOA			dence 6 ⊡Othe	
E a age	tlon:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Yea	28b. Time of Injury	28c. Inju Wo M 1 □	yat rk? Yes 2∐No	28d. Describe I	now injury occurre	bed
or A ftar ftar in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - building, etc. (S)	At home, farm, stropecify)	eet, factory, office		28f. Location (3 City or Tox	Street and Numbe vn, Stete)	er or Rural Route Number
Ne Hospital on 24 hours and Funeral Dipletely filled	edical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my ner: On the basis of exam and manner stated.	r knowledge, death mination end/or inv	occurred at the tirestigation, in my o	me, date and place opinion, death occu	and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
To the within To the comple	ž	29b. Signature end title of certifier	///		29c. Licens	e number		29d. Date signed	(Month, Dey, Yeer)
		Land Ch			D2.	5079		3 3	oe s
Min		30. Name end address of person who co	mpleted cause of death	(Item 23e) (Type,	Print)				
67		Don H. Yablonowi	tz, MD 74	04 Execu	tive_Pla	ce, Suite	e 502, L	anham, M	D 20706
S	ate	31. Date filed (Month, Dey, Year)	32. Registrer's S						

DHMH 16 Rev 6/95

			For State Registrar	State of Maryland		artment of H			iene	09885
	Physici	an	1. Decedent's Name (First, Middle, Last)  John David Sto	olarik				2. Date of Death March	1, 2006	3. Time of Death 4:00P. M
	/Medic Examin		4a. Facility Name (If not institution, give s 4310 Van Buren St			4b. City, Town, or Univers	Location of Dea		4c. County of Deat Prince G	
	Funeral Director		5. Social Security Number 6. Sex 102-20-5280 1X	M 2□ F 7. Age (In yrs. I		Il Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birth	hplace (State or Foreign y <sup>nt</sup> T)sland, N.Y.
	Maryland f ehow	ior	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		Town or Lo	cation ty Park				10d. Inside City Limits 1 X Yes 2 □ No
	3a or 28a-	Funeral Director	10e, Street and Number 4310 Van Buren Stre	eet		10f. Zip Code	20782	10	Og. Citizen of What Co United St	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hyglene. Importants if Item 27 is marked other then "natural", or Iteme 23e or 28e-f ehow any Injury or other treumatic evant, The Medical Exattrical must be notified at any Injury or other treumatic evant, The Medical Exattrical must be notified at an ODGE.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 (XYes 2 No If Yes, Give Year or Dates: (un)		Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:			14. Race - Ame Black, White Specify: Wh	
21215-0036	within 72 ho ene. then "natur he Medical	To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (9212)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wa	orking	16b. Kind of Business/ Goddard Spa	
	uld be fited fental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last) John	Stol	larik		18. Mother's Na Stepha	ame (First, Middle, Many	Maiden Sumame) Planet	ta
, Mary	and 2 shousaith end N		19a Informant's Name/Relationship (Tyr. Ellen Stolarik -wii	pe, Print) [e	19b. Mailir 4310	ng Address (Street: Van Bure	and Number or F en Street		City or Town, State, 2 ity Park, I	
Baltimore, Maryland	Pages 1 ament of He tant: If Item jury or other		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Meti	opoli	sition (Name of matory or other place tan Crema	tory 3/	13/2006 A	20c. Location - City or Alexandria	, Virginia
Ball	Departiment Departiment Important Im		21. Signature of Funeral Service License	Borgward						ryland 20705
8760,	death certificate be executed  Ex  We estending physicien and id for use as the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Metastatic  Due to (or as a consequ	Lung uence ol):					Interval Between Onset and Death
P.O. Box 6	death certifi le ettending   ed for use as	ysiclan/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1						23d. Date ol del Month	ivery Day Year
	w requires that the best speed by the should be detacht	ρ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.		pacco use contribute to	the cause of death?
of Vital Records,	The la ate hes page 2	Completed						24a. Was ar autops perform 1 Yes 2	y prior to death?	stopsy lindings available completion of cause of 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth		eath Check only one	***	
on of	After	tion; To	1 Yes 2 No 1  27. Nanner of Death 14 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injur	4 Linursing	28d. Describe ho	once 6 Other (Spec ow injury occurred	ony)
Division	al or Attend s after death al Diractor:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,			
	To the Hospital or Atti within 24 hours after de , To the Funeral Diracti	edicai	(Check only 2   Medical Examir	ician: To the bast of my kno ter: On the basis of examina and manner stated.	wledge, daat tion and/or in	vestigation, in my o	pinion, death occ	curred at the time, da	ate and place, and due	to the cause(s)
	To with	Σ	29b. Signature and title of certifier	, welltz			23743	1	9d. Date signed (Mont.) March 13, 2	2006
	do		30. Name and address of person who co Martin D. Weltz, N				.,#205	Greenbelt,	, Maryland	20770
	Sta Regist		31. Date liled (Month, Day, Year) MAR 1 6 20	32 Registrar's Signa	ture	well)				

CPM 06-01803 Mary Talley

		For State Registrar	Ce	rtificate of Death	Reg.	<b>2</b> .006 09880
Physicia /Medic	an	Decedent's Name (First, Middle, Last) Mary Margaret Talle	У		2. Date of Death Month March 1	Day Year 3. Time of Death 19:00
Examin Funeral Director	er	a. Facility Name (If not institution, give street  Suburban Hospital  5. Social Security Number  215-44-5106  6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea  Bethesda  If Under 1 Year   If Under 24 Hrs  Months Days Hours Min	8. Date of Birth	4c. County of Death  Montgomery  9. Birthplace (State or Fore Country) 1916 Pennsylvania
2	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lim
death with the Maryland ims 23a or 28a-f ahow [Instal be notified at	5	Maryland Montgomery  Oe. Street and Number		10f. Zip Code	10g.	1 ☐ Yes 2 ☑  Citizen of What Country?
al', or ite	by Funeral	1 Never Married 2 Married 1	las Decedent Ever in U.S. med Forces?  Yes 21 No Yes, Give ear or Dates:	20902  Was Decedent of Hispanic Origin? (stiff Yes, specify Cuban, Mexican, Puer 1 ☐ Yes    Z No Specify:  Ident's Usual Occupation		USA  14. Race - American Indian, Black, White, etc.  Specify: White
r then "nat	Completed	(Specify only highest grade com	opleted) (Give life.	s kind of work done during most of wo DO NOT use retired) Iomemaker	rking	Own Home
z should be filed within and Mental Hygiene. Is marked other then sumatic event, tra Me	To Be C	7. Father's Name (First, Middle, Last) Chester E. Carles			me (First, Middle, Mail	den Sumame)
Health and N		19a. Informant's Name/Relationship (Туре, Р Richard C. Talley/ S		ng Address (Street and Number or R Thayer Street,		
Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natur any injury of other traumatic event, the Medical angle."		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	osition (Name of matory or other place)  1 Cemetery	ch 18,	Location - City or Town, State
Departr Importe any inju		21. Signatur of Funeral Service Licensee		ት ትክሮት \$^dgess ሮቼዊ living 00 University Bl		Home Inc Lver Spring, MD 20
hysician /Medical Examiner		23a. Part1. Enter the disease, of complication shock, or heart failure. List only one car Immediate Cause (Final disease or condition resulting in death)		es with Compl		Onset and Death
physicien and as the burial-transit	edical Examiner	Sequentially list conditions, fany, leading to immediate auss. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):			
e attending	Σ	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	<u>۸</u>	Part II. Other significant conditions contribut	ing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
e e e	d by				1 🗀 Yes	2 No 3 Probably 4 Unkno
ete has been signe page 2 should be o	Completed by				1 Yes  24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings availad prior to completion of cause death?
raficete has been signe ctor, page 2 should be o	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 □ No	1 ∆Unpatient 2 □ ER/Outpatier	nt 3 DOA Other: 4 Nursing I	24a. Was an autopsy performed.  1 X Yes 2 Dath Check only one)	24b. Were autopsy findings availabrier to completion of cause death? No 1
raficete has been signe ctor, page 2 should be o	To Be Completed	25. Was case referred to medical examiner?  1X Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	al: 1 Inpatient 2 ER/Outpatien  a. Date of Injury (Month, Day Year)  3 - 2 (- 0 13 4 19 19 19 19 19 19 19 19 19 19 19 19 19	ont 3 DOA Other: 4 Nursing I  28c. Injury at Work?  M 1 Yes 2 No  reet, factory, office	24a. Was an autopsy performed 12 Yes 2 ath Check only one 28d. Describe how 128d. Describe how 128d. Describe how 128d.	24b. Were autopsy findings availar prior to completion of cause death? No 1 A Yes 2 No  6 Other (Specify)  Injury occurred  A A Number or Rural Route Number,
raficete has been signe ctor, page 2 should be o	Certification: To Be Completed	25. Was case referred to medical examiner?  1	a. Date of Injury (Month, Day Year)  - 24 - 0 28b. Time o Injury  - 3 - 4 - 0 3 4  e. Place of Injury - At home, farm, str building, etc. (Specify)	ont 3 DOA Other: 4 Nursing I of 28c. Injury at Work?  M 1 Yes 2 No reet, factory, office  h occurred at the time, date and place	24a. Was an autopsy performed to the check only one dome 5 Residence 28d. Describe how in the city or Town, Sa, and due to the caus	24b. Were autopsy findings availar prior to completion of cause death? No 1/2 Yes 2 No  6 6 Other (Specify)  Injury occurred  It and Number or Rural Route Number, late)  (s) and menner as stated.
ete has been signe page 2 should be d	Medical Certification: To Be Completed	25. Was case referred to medical examiner?  1	a. Date of Injury (Month, Day Year)  B. Place of Injury - At home, farm, strength of the building, etc. (Specify)  To the best of my kin sedge, death on the basis of examination and/or in the days of examination and/or in the days of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the days of examination and/or in the basis of examination and/or in the ba	ont 3 DOA Other: 4 Nursing I  28c. Injury at Work? 1 Yes 2 No  reet, factory, office  th occurred at the time, date and place investigation, in my opinion, death occurred.  29c. License number  O.C.M.E.	24a. Was an autopsy performed the Check only one dome 5 Residence 28d. Describe how in City or Town, Sea, and due to the causurred at the time, date	24b. Were autopsy findings availar prior to completion of cause death? No 1/2 Yes 2 No  6 6 Other (Specify)  Injury occurred  It and Number or Rural Route Number, late)  (s) and menner as stated.

			1 - For State Registrar	State of Mar	-	artment				lental Hy	/gier Reg. <del>f</del>	20116		9887
			1. Decedent's Name (First, Middle, Las	t)						2. Date of D Month		Day Ye	20	3. Time of Death
	Physici /Medio		HILDA C. UTERMOHL	E		,					10	2006		8:15 a <sup>M</sup>
2	Examir	ner	4a. Facility Name (If not institution, give					Location of	of Death			c. County of E		_
		Se .	6000 Greenvale Pa 5. Social Security Number 6. Se		'In yrs. last birthday	-	erda	Le If Under	24 Hrs	8. Date of B		Prince		
<b>X</b>	Funeral Director		217-26-7385	M 2⊠F	77 Yrs.	Months	Days	Hours	Min.	Feb. 2	3, Yea	929 M	Count	ace (State or Foreign ry) Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation							10	d. Inside City Limits
	Mary i-f sh	ţ	Maryland Prince G	eorge's	Riverda1	0								1 ☐ Yes 2X No
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Exemiter must be notified at	Director	10e. Street and Number		11-102441	10f. Zip	Code				10g. (	Citizen of Wha	t Count	ry?
	23a	la C	6000 Greenvale Pa	rkway		207	737				U.	S.A.		
	tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Deced	ent of Hi	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V		
36	rs afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	∑ No	Specify:				Specify:	Whi	te
9	2 hou	led	15. Decedent's Ed		16a. Dece	dent's Usua	l Occupa	ition			16b.	Kind of Busine		
215	hin 72	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	uring mosi )	t of work	ing				,
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan lat Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, the Madzel Exterior must be notified at	Completed		2		maker						n Home		
DG.	be file	Be	17. Father's Name (First, Middle, Last)							e (First, Middle	e, Maide	en Surname)		
<u> </u>	should be nd Mental marked o	၉	Thomas Callis		T					ckson				
ā Z	s 1 and 2 should if Health and Men Itam 27 te marke other traumatic		19a. Informant's Name/Relationship (7)  John R. Utermohle			-						or Town, Sta.		,
ē,	1 and Heali Iam 2		20a. Method of Disposition	- nusband	20b. Place of Disposemetery, cre				_	, Rive: Date	-	e, Mar Location - City		nd 20737 vn, State
<u>o</u>			1 🕅 Burial 2 /□ Cremation 3 □ 4 □ Donation 5 □ Other (Specify						3/1	4/2006	C-i	1220 r Cr	rin	g, Marylan
	교문문을 .		21. Signature of Funeral Syrvice Licen		2	2. Name an	d Addres	s of Facilit	y Ga	sch's ]	Fune	ral Ho	me.	P.A.
ñ	Depa Depa Impo any i		by L. Ticheel									sville	11.7	
	13.59		23a. P.11. Enter the disease, or comp	dations that caused the cause on each line.	e death. Do not en	ter the mode	e of dying	, such as	cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician	. 1	Imm nate Cause (Final disease or condition	a Metastat:		Maligr	ant	Mu11	eria	n Tumo	r of	the		Onset and Death  Months
	/Medical Examiner		resulting in death)		consequence of):			11022					1	110110110
	Lxammer	L	Sequentially list conditions, if any, leading to immediate	b										
	pei tist	ulue	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):									
	ah-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):									
8760	cale be executed physician and the burial-transit	dical E	l	d										
89	g phys			· ·										
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		⊒Ectopic pre	annancv					23d. Date of		
О.	he att	sicia	in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	4 ☐ Pregnant at tir		Other (spe						Month	[	Day Year
<u> </u>	d by the a	Phy	9 Unknown  Part II. Other significant conditions co	nichutian to doub but	ant constitute in the			- i- O I		220 Did		a usa sastribut	a ta tha	cause of death?
S,	ries that signed t	by	ratti. Other significant conditions of	intributing to death but	not resulting in the t	indenying ca	iuse give	m in ran i.						bly 4 Unknown
ŏ	w requir been si should	Completed												
Re	The law cate has page 2:	m ld									s an opsy ormęd?	prior	to com	sy findings available pletion of cause of
<u>a</u>		e Co	25. Was case referred to medical					00.01	- ( D	1 Yes	2🗶 ۱		Yes 2	?□ No
5	Attanding Physician: r death. sctor: After this certific by the funeral director.	To Be	examiner?	Hospital: 1 □ Inpatient	2 ER/Outpatie	nt 3 DO	A Othe	_		h (Check only		6 □Other (S	Snocify	
ō	g Ph ler thi		27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o		Bc. Injury Work			28d. Describe			<i></i>	
Ö	ttending I death. ctor: After y the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		out/ Injury	м		'es 2 □ i	No					
Division of Vital Records,	i Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		reet, factory	, office			28f. Location City or To			r Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 X Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of iner: On the basis of e and manner state	xamination and/or in	th occurred anvestigation,	at the tim in my op	e, date an inion, dea	d place, th occur	and due to the red at the time	cause , date a	(s) and manne and place, and	r as sta due to	ted. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·		29c	. License	number			29d. E	Date signed (M	Ionth, D	lay, Year)
)	10		1 Caller	MO			D227	55			Ма	rch 13,	20	06
	Q.A		30. Name and address of person who o	·		, Print)								
	BJ		Christine deLima		Van Duser	Road	, #2	60, I	laure	el, Mar	y1a	nd 2070	)7	
357	Sta	te	31 Date filed (Month, Pax (Year)	32. Redistrar	E DOGE									

DHMH 17 Rev 1/2001

Registrar

			1 - For Stete Registrar	State of M	arylan		artmen <i>tificat</i>			ind M		iene <sub>g. No.</sub>	06	09	888
	Physici	an.	1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month	h Day	Yea		ne of Death
	/Medic		LUBOV	Y .		VASI					MARCH	13			2:35A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give s				, ,		Location o				4c. County of Death PRINCE GEORGE 'S		
			12806 WOODMORE R		a (In vrs	last birthday)		1 Year	ELLVI		8. Date of Birth				
L	Funeral Director			M 253F	101	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year) 190	9. Birthplace (State Country) RUSSIA		ate of 1 oreign
			Usual Residence of Decedent							1	122.				
	ahow	_	10a. State 10b. County			y, Town or Lo		T.							de City Limits Yes 2 ☐ No
	88a-f	Director	MD PRINCE G	EORGE'S	M.	ITCHEL									
	Mith th	D I	10e. Street and Number				10f. Zip					•	n of What	Country?	
	eath se 23	era	12806 WOODMORE ROA	D 12. Was Decedent	Ever in U	S 13 V		0721	soanic Oric	U.S.A. ic Origin? (Specify Yes or No-					n
	ther d	Funerai	1 Never Married 2 Married	Armed Forces		'	f Yes, spe	cify Cubai	n, Mexican	, Puerto I	Rican, etc.)		Black, W	hite, etc.	••••
9	urs a	ρ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2. X No	Specify:			S	pecify:	WHITE	
2	72 ho	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced	ient's Usu	al Occupa	ition Juring most	of working	na	16b. Kind	of Busine	ss/Industry	
2	ithin Ne.	du	Elementary/Şecondary (0-12)	College (1-4or	5+)		JSEWI		luring most )		,,	PRT	VATE		
2	led w lygier her th	S	12th		_	not	DEW T.	L 12	10 Moths	da Nama	(First, Middle, I				
ano	ntal H	To Be	17. Father's Name (First, Middle, Last) YAROSLAV SOCHVA	ANOV						EZHD			imamej		
2	hould d Me mark matic	۲	19a. Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailin	na Address	(Street a	and Numbe	r or Rura	l Route Number	City or 7	own. State	a. Zip Code)	
<u>≅</u>	Ith ar 27 is r trau		VERA GARTHOFF/DAU				-				TCHELLV				0721
ē,	s 1 ar		Cemetery, crematory or other place)								20c. Loca	Oc. Location - City or Town, State			
Ë	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinat must be notified at once.		1 ☐ Burial 2X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		VERDAL				/14/	2006	RIVE	RDALE	,MARYI	AND
Baltimore, Maryland 21215-0036	mit. spartn ports y inju		21. Signature of Funeral Service Licensi	00		22	. Name ar	d Addres	s of Facility	у Ј.	B. JENI	KINS	FUNE	RAL HO	ME
<u> </u>	89 E 2 8			2			7474	LAND	OVER :	ROAD	LANDOV	ER, M	IARYL	AND 20	785
	Physician		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each l	ine	h. Do not ent						est,			cimate il Between and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions		a conseq NARY	uence of): ARTER	Y DIS	EASE							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
	cate be executed oblysician and the burial-transit	Examiner										+			
8760,	be ey iician buria	alE	<u> </u>												
687	ficate p phys is the	edic													
Вох	eath certific attending pl for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23	d. Date of	delivery	
о. В	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1  Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic p Other (sp						Month	Day	Year
٥.	that the by detail		Part II. Other significant conditions cor	ntributing to death I	out not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did tol	oacco use	contribute	to the cause	e of death?
rds	w requires to been signer should be	ed by	OSTEOPOROSIS								1 □ Ye	es 2 🔯	No 3□	Probably	4 □Unknown
000	aw rec as bee 2 shor	Completed									24a. Was a	n :	24b. Were	autopsy find	ings available of cause of
Re	The la	E									autops perform	ped?	death	to completion ? es 2 No	
ta	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			- 1			26. Place	of Death	Check only on	100			
<b>&gt;</b>	Physician: r this certific ral director,	To	1 ☐ Yes 2 🛣 No	łospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatien	nt 3□ D0	Oth 6	er: 4 □ Nu	rsing Hor	me 5∭ Reside	ence 6[	Other (S	pecify)	
ت 0	ding PI n. After ti funera		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Da	ıry ıy Year)	28b. Time of Injury		28c. Injury Work			28d. Describe ho	ow injury o	occurred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	20 21 (1)		(	М		/es 2 □ !		204 Landina (S		VI	0 10 1	A4
Division of Vital Records,	al or Atten after deat Director: d in by the	Certification;	4 Homicide determined	28e. Place of In building, e			eet, factor	у, опісе		4	28f. Location (Si City or Town		vumber or	Hurai Houte	Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examione)	sician: To the best	of examina	wiedge, death	n occurred vestigation	at the tim , in my op	ie, date and pinion, deat	d place, a	and due to the ca	ause(s) at ate and p	nd manner lace, and c	as stated. due to the car	use(s)
	To the within 2 To the complex	Med	29b. Signature and title of senting	and manners	alou.		29	c. License	number		2	9d. Date	signed (Mo	onth, Dey, Ye	ar)
)	⊢ 3 ⊢ 8		IN ATT V	MKI	1			<del>D90</del> 5.	3946			MARC		3, 200	
	i		30. Name and address of person who co												-
4-	1		NADIA AKHMED M.	D. 205 R	DGEL	EY AVE	NUE A	NNAP	OLIS,	MAR	YLAND 2	1401			
4	Sta		31. Date filed (Month, Day, Year)	32. Regist		ature									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician FLORES** VILLANUEVA **PEDRO** 4:15P M 14,2006 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 618-04-6114 62 Director 27,1943 Mexico Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits -how in then "naturel", or iteme 23a or 28a-f ehove the Medical Examiner must be notified at 1 CYes 2 No Completed by Funeral Director Germantown MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13603 Ambassador Drive 20874 Mexico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of health and Mental Hygiene.
net if Item 27 is marked other than "naturel", or Itel
119-97 other traumatic event, the Madical Emptiment 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 XYes 2□No Specity: Mexican White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Korner Bakery 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Margarita Villanueva Flores Clemente 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13603 Ambassador Dr Germantown, MD 20874 Maria T. Flores- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Support of 1 DXBurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any Injury or once. 3/17/06 Germantown, MD All Souls Cem 4 □Donation 5 □ Other (Specify) 21. / ignature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MUCCARNAZ YINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, use as the IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete 1 Yes 2 No 1 ☐ Yes 2 10 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2√No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) CENTER DR. ROCKVILLE MOUICOR AUID SROUR 32 Registrar's Signature 31. Date filed (Month, Day, Year) 16 2006 Registrar

NLM 06-02092 Thomas Walter

as walle	ST.	1 - For State Registrar	'''' 'State 'or Maryta		irtment of tificate of			ene, 006	09890
Physic /Med		Decedent's Name (First, Middle, La.	THOMAS	XAVIER	R WALT	ER	2. Date of Death Month March	Day Year	3. Time of Death 3:17 P M
Exam		4a. Facility Name (If not institution, given 215 North Seton A	venue		Emmits			4c. County of Death	ick
Funera Directo		5. Social Security Number 6. S 212-72-6054 1  Usual Residence of Decedent	A Age (In yr	46 Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Feb. 6,	Year _ Co	nplace (State or Foreig untry) rginia
Maryland a-f ahow	tor	10a. State 10b. County	lerick 10c. 0	City, Town or Lo	cation nmitsbu	ırg			10d. Inside City Limit:
h with the 23a or 28s	al Director	10e. Street and Number 215 North Set	on Avenue		10f. Zip Code 217			og. Citizen of What Conited Sta	
within 72 hours after deeth with the Maryland with in the maryland liene. Then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	II	Vas Decedent of Yes, specify Cu ☐ Yes 2X N	Hispanic Origin? (Sp lban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
within ane. then	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give		upation e during most of work red) n worker	ing	6b. Kind of Business/I	,
build be filed Mental Hygiarked other atic event,	To Be C	17. Father's Name (First, Middle, Last) John H. Walte					e (First, Middle, M gnes Bu		
		19a. Informant's Name/Relationship ( John H. Walte	* *					City or Town, State, Z Emmitsbu	
Dermit. Pages 1 end Department of Healt Important: If Item 2 any injury or other		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	Place of Dispos cemetery, crem ithsbur	natory or other p		r. 26	Oc. Location - City or T	Town, State
permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licer	Furon	2	10 W. Ma		Emmitsk	ourg, Md. 2	21727
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any Isology to innectate cause. Enter Underlying	plications that caused the de one cause on each line.  a. Diabetic ketch Due to (or as a constitution of the constitution of t	acidosis equence of):	er the mode of d	ying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
ficate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse	equence of):					
law requires that the death certifics so been signed by the attending pt 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	ital death 3	Ectopic pregnan Other (specify)	су		23d. Date of delin	very Day Year
w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the un	nderlying cause o	given in Part I.		acco use contribute to	_
The ate h	Completed						24a. Was an autopsy perform 1 Yes 2	prior to c	topsy findings available ompletion of cause of
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?					h (Check only one	)	
ling After une	tlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In		me 5 XResider 28d. Describe how	nce 6 Other (Spec winjury occurred	ufy)
al or Attend s after death al Dirsctor:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	DB Class of Injury At home form street feature (feature form)						
To the Hospital or At within 24 hours after of To the Funerel Dirsc completely filled in by	edical (	(Check only one)	ysician: To the lest of my k niner: On the basis of exami and manner stated.	nation and/or inv	occurred at the restigation, in my	time, data and place, opinion, death occur	and due to the cai red at the time, da	te and place, and due	stated. to the cause(s)
To the within To the comple	×	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Month	, Day, Year)
		· Um 2				.C.M.E.		March 26,	2006
		30. Name and address of person who	10, MD		111 P	enn Street	Baltimo	re, Maryla	nd 21201
S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 3 0	32. Registrar's Sig	nature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Tillman 2006 Williams Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Lanham Prince Georges Doctors Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Months Hours 1X M 2□ F 248-30-2556 Yrs 80 JULY 20 1925 SOUTH CAROLINA Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10h County 1 Yes 2 □ No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2957 HOBBLE BUSH COURT 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No BLACK Specify Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Private Construction 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Corbitt Williams Sr. Tillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8703 McLain Ave, Glenarden, MD 20706 Annett Williams/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 03/20/2006 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Rd., Landover, MD 201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL FAILURE disease or condition resulting in death) Due to (or as a consequence of) LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit

nding physicien and

certificate

after death.

24 hours a

within 2 To the

P.O. Box 68760

Division of Vital Records,

Department of Health a Important: If Item 27 Is any injury or other traigness.

Pages 1 ment of P

**Physician** 

/Medical

Director

Completed by Funeral

Be

Examiner

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. I have 12 is marked other than "natural", or Items 23s or 28s-f show ther traumatic event, the Medical Examinar must be notified at

Examiner Physician/Medical Be Completed by page 2 should be

Certification: To

Medical

filled in by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

DEMENTIA

1 Yes 2 No 3 Probably 4 Denknown 24a. Was an autopsy performe 217 No 1 Yes

25. Was case referred to medical examiner? pital: 1 | Inpatient 2| 28a. Date of Injury (Month, Day Year) 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural 5 Pending

investigation

6 Could not be determined

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 🗌 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

MN

D0058290

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mun

SURESHKUMMAR HTATTUM 4203 QUEENSBURY RD. HYATTSVILLE, MD 20181

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 6 2005



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** VIRGINIA C. WANTZ MARCH 11, 2006 4:45 A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL LA CASA ASSISTED LIVING ANNAPOLTS If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs. Director 212 52 7847 95 AUG.14,1910 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Iteme 23a 105 EDGEHILL ROAD 21405 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2√∑ No Specify: 3 ₩ Widowed 4 Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth eny lipury or other treumatic event 2008. 2 JOHN R. CRUNKLETON MARY ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Edgehill Rd., Annapolis, MD 21405 CAROLYN W. DENTON (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee Kalas Crematory Edgewater, MD 03-13-06 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Uno Cancer Physician disease or condition resulting in death) /Medical Due to (or as a conseque to of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No To the Hospital or Attending Phywithin 24 hours after death.

To the Funerel Director; After this completely filled in by the funeral: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: LIVING 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PO52023 maric MARCH 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) annapolis, Ma 21401 MARIA ROMERO Defen to have MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2006

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 30:90w Son 015 March 10 Jean 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4b. City, 1000 April 24 Drs.

H Under 1 Year If Under 24 Drs.

Months Days Hours Min.

Min.

Month, Day, Year) Hospita Dorchester Dorchester General 7. Age (In yrs. last birthday)

( Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 218-34-873 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the and Mental Hygiene. It is marked other than "natural", or Itams 23a or 28e-f show other transitions of the Medical Examine must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No To Be Completed by Funeral Director appe 01 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 -atewa 12. Was Decedent Ever in U.\$. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISaac ora inder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 OC e a la 20b. Place of Disposition (Name of cometery, crematory or other place) Gateway 20c. Location · City or Town, State 21673 James 20a. Method of Disposition Date Department of Himportent: If its any injury or ot once. 1 → Burial 2 □ Cremation 3 □ Removal from State 06 Paradise Cometery ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part I first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (First) MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis Syndrom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tract Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co sequence of) Examiner for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 No 1 SInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 🕆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

408

32. Registrar's Signature

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2006

Murk

31. Date filed (Month, Day, Year)

			For Stata	State of M		nd / Depa	artment of	Health	and Me	-		•	19891
	9		Registrar			Cel	tificate o	T Deal			Reg. No	).	
	Physici	an	Decedent's Name (First, Middle,							<ol><li>Date of De Month</li></ol>	Da		3. Time of Death
	/Medic		Elizabeth War							3	6	06	1000 am
d	Examir	er	4a. Facility Name (If not institution, g		/ -	1	4b. City, Town	, or Locatio	on of Death		40	. County of Deat	
				nal medica		nter	If Under 1 Ye	150	der 24 Hrs.	2 D (D)		Willen	
	Funeral			. Sex 7. A 1 □ M 2 🖾 F	nge (In yrs. 83	. last birthday) Yrs.	Months Day		s Min.	8. Date of Bir (Month, Da	y, Year,		hplace (State or Foreign untry)
	Director		222-09-7669 Usual Residence of Decedent			110.				Sept.	12,	1922 D	elaware
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
ول	Mary	ō	De Suss	ex	I	Laurel							1 ☐ Yes 2 ☑ No
7669	deeth with the Maryland ms 23s or 28s-f show rrust be notified at	Funeral Director	10e. Street and Number				10f. Zip Code	9			10g. Ci	tizen of What Co	untry?
	3a or	0	31843 Gordy Roa	d			100	956				II C A	
Z.	The 2	era	11. Marital Status	12. Was Deceder	t Ever in U	J.S. 13. \	Was Decedent of t Yes, specify C		Origin? (Spec	city Yes or No	)-	U.S.A. 14. Race - Ame	
222	r Her	교	1 ☐ Never Married 2 X Married	Armed Forces	?					Rican, etc.)		Black, White	e, etc.
23	hours after tural', or its al Examina	β	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1□Yes 2□X1	lo Spec	ify:			Specify: W	hite
5-0036	72 ho	ted	15. Decedent's	Education		16a. Deced	dent's Usual Occ	cupation	and of undia	-	16b. K	(ind of Business/	Industry
	within 72 ene. then "ne	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work do DO NOT use ret	ired)	iost or working	9			
ರ್ಹಿ d 2121	gien er th	Completed	12			M	edical :	Secre	tary		D	octors (	Office
) E	be filed Ital Hygi d other event, I	Be (	17. Father's Name (First, Middle, La	st)				18. Mc	other's Name	(First, Middle	, Maider	Sumame)	
₹a	should the nd Ment marked umatic	10	John Scott					E	dna Ba	ker			
E۱۱۶۵۷ فکیر ا ee, Maryland	and and fe m		19a. Informant's Name/Relationship									or Town, State, 2	Zip Code)
	permit. Pages 1 and 3 Department of Health Important: If Itsm 27 any injury or other tr. once.		Frank Ward/Hu	spand 			3 Gordy						
EN: Baltimore,	of H of H if its		20a. Method of Disposition 1   Burial 2   Cremation 3	☐Removal from Stat	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other p	olace)	Da	ate	20c. L	ocation - City or	Town, State
<u>Ē</u>	Pag ment ant:   ury c		4 ☐Donation 5 ☐ Other (Spe				vs Cemet				Lau	rel, Del	laware
alt	Departi Departi Import any inj		21. Signature of Funeral Service Lic	ensee	,	22	. Name and Ade	dress of Fa	cility Han	nigan-S	Shor	t-Disha	roon F.H.
ш	20129		abolly shoot	- danne	land		700 Wes					19956	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cause ty one cause on each	ed the dea line.	th. Do not ent	er the mode of o	tying, such	as cardiac or	respiratory a	rrest,		Approximate Interval Between
T	Physician		Immediate Cause (Final disease or condition			Subdu	al her	restor	Y.				Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consec	quence of):	d level	· (	,				7
	Examiner		Sequentially list conditions.	b			d level	fal	.1				
	p #	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consec	quence of):							
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cam	that initiated events resulting in death) Last	c									
760,	oe ex	Û	rosaning in dodiny East	Due to (or a	s a consec	quence ot):							
87(	ate to			d									
x 68	ing p	Me	IF FEMALE:										
Box	ath c	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 ☐Feta	aldeath 3□	Ectopic pregna					23d. Date of del Month	ivery Day Year
o.	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of o	death 5∟	Other (specify)						,
P.O.	hat the d by	by Physician/Med	Part II. Other significant condition	contributing to death	but not rea	sulting in the u	nderhina cause	gwen in Pa	ort I	23e Did t	obacco	use contribute to	the cause of death?
ds,	signe d be		•	, , , , , , , , , , , , , , , , , , ,		Jan. 19 111 1110 111	1301171119 34433	9.70		10			obabiy 4 Unknown
Ö	redu	Completed								-			
ec Sec	elaw hast	ldu								24a. Was		prior to death?	topsy findings available completion of cause of
-	cete	S								1 ☐ Yes			2□ No
Zi.	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:	,		1,	Oth or:		(Check only o			
4	Phys this aldir	ဥ	1 📝 es 2 ☐ No 27. Manner of Death	28a. Date of In		ER/Outpatien	T 3L DOA			e 5 Resi		6 Other (Spe	cify)
Division of Vital Records,	Jing After funer	Certification;	1 □Natural 5 □ Pending	(Month, D	ay Year)	Injury		ijury at Vork? □Yes 2		around	,	. ^	
:5	death death ctor: / the	icat	2 Accident investigat 3 ☐ Suicide 6 ☐ Could no	be Gen Blace et 1		1100	eet, factory, offic						ural Route Number,
Š	or A after Direction by	it.	4 Homicide determine	building,	etc. (Speci	ify)	eet, ractory, one	20		City or To	wn, Stat	e) . La	enel, DE
_	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificele has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 ☐ Certifying	Physician: To the bes	st of my kn	owledge death	occurred at the	time date	and place, a	nd due to the	Causels	) and manner as	19956 stated
	24 h	Medicai	(Check only 2 Medical Ex	aminer: On the basis and manner:	of examina	ation and/or in	vestigation, in m	y opinion,	death occurre	d at the time,	date an	d place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Lice	ense numb	er		29d. Da	ite signed (Mont	h, Day, Year)
	r s ⊢ ō		) Church	DW	F		144	3049	)		310	106	
	(11)	6	30. Name and address of person wh			m 23a) (Tyne		5-VI)			J 1	1 -	
	(me)		Chris Smor Di		2241. (110		Carol	15.	S	ulisby	W	108150	
	Sta	te	31. Date tiled (Month, Day, Year)	1.00	trar's Sign								
	Registr		MAR 1 / 20	20	,								

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan	•	artment of H tificate of L			ene g. No.2 () () ()	00005			
			Decedent's Name (First, Middle, Last	7)				2. Date of Death	1	3. Time of Death			
	Physici /Medic		JOHN RUSSELL Y	ATES, III				MARCH	$1^{\text{Day}}$ $20^{\text{Year}}$	5 12:05AM			
7	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	ath			
			SHADY GROVE ADV  5. Social Security Number 6. Se			ROCKV	ILLE If Under 24 Hrs	S I O Date of Blat	MONTGO				
	Funeral Director		218-53-6034	x, 7. Age (In yrs. I	Yrs.	Months Days	Hours Min		Year C	rthplace (State or Foreign country) SH., DC			
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits			
	Mary	tor	MD MONTGOI	MERY DI	CKERS	ON				1 ☐ Yes 2 1 No			
	with the a or 284 Le not	Director	10e. Street and Number 19016 WASCHE RO	DAD		10f. Zip Code 2084	1	10	og. Citizen of What C	ountry?			
	ms 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.	S.   13. \	Vas Decedent of Hi	spanic Origin? (	Specify Yes or No-	o- 14. Race - American Indian,				
326	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23a or 28a-f ehow he Medical Examinat must be notitled at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	fYes, specify Cuba I□Yes 2☑No	n, Mexican, Puei Specify:	rto Rican, etc.)	Black, White, etc.  Specify: WHITE				
21215-0036	"naturel",		15. Decedent's Edu	cation	16a. Deced	lent's Usual Occupa	ition	1	6b. Kind of Busines:	s/Industry			
2	ithin 7 ne.	Completed	(Specify only highest grad	College (1-4or 5+)	`life. L	kind of work done of OO NOT use retired,	uring most or wa )	orking	WHOTO				
	e filed w Il Hygier other ti vent, In	S	17. Father's Name (First, Middle, Last)	3	PROM	IOTER	18 Mother's Na	ame (First, Middle, M	MUSIC				
Maryland	d b Senta	To Be	JACK YATES					Y SHEIRY					
	12 s h ar 7 te		19a. Informant's Name/Relationship (7)	ype, Print) ATHER				Rural Route Number, DICKERS		Zip Code) 20841			
altimore,	- I 5 =		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ I			sition (Name of natory or other place	9)		0c. Location - City o				
Ĕ	Pa intra		4 □ Donation 5 □ Other (Specify)	FRE		K CREMA		/17/06	FREDERIC	CK, MD			
Ra	permit. Pag Department Important: any njury o		21. Signature of Fureral Service Licens	600	H	Name and Addres	UNERAL	HOME ARNESVIL	LE, MD	20838			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death	-					Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Six n Si	C					Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):								
	LXammer	1	Sequentially list conditions,	b. Due to (cr as a consequence	mon	ia				Nours			
	uted I Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
oʻ	exected and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consequ									
9/8 8/90	icate be executed physicien and the burial-transit	dicai		d									
٥	ding p	/Med	IF FEMALE:	23c. If yes, outcome of pregnar	ncv								
X Q Q	death certifi e ettending id for use as	ician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year			
J.	the sche	Physi	9 Unknown	9□ Unknown									
Records, 1	6 50	Ď	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the ur	iderlying cause give	n in Part I.			robably 4 Debaknown			
င္ပ	s been si	olete						24a. Was an	24b. Were a	utopsy findings available			
	sician: The law certificete hes b irector, page 2 st	Completed				-		autopsy perform	prior to	completion of cause of			
VITA	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Otho		eath Check only one	)				
0	Phy rald	٤.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		4   Nursing I	Home 5 Resider		ecify)			
0	Attending Phy r death. ector: After thi by the funeral	at lon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ No	Edd. Describe not	in injury occurred				
UIVISION	ol or Attendi after death. I Director: A d in by the fu	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Tural Route Number,			
	ospite hours uneral iy fille	edicai C	(Crieck only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death ion and/or inv	occurred at the tim	e, date and plac inion, death occ	e, and due to the car surred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)			
	To the H within 24 To the Fi complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Mon				
,	⊢≯⊢ŏ	1	10 los	0		D36	979		-				
1	3		30. Name and addres of person who co	ompleted cause of death (item	23а) (Туре,	Print)		1//	vuch 14	2006			
-			Deburah Sher	011 MD 9901	me	lical CE	nterp	r. Rocki	ville, t	12006 1020850			
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 7	32. Registrar's Signat	ure A	heeles			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State\_of Maryland./\_Department of Health and Mental Hygiene 11 11 6

			1- Famend Item#19		353 <sup>123</sup> ,	731706 Cel	tificate of	lealth and Death	Mental Hyg	giene     Reg. No.	Jb	19090
	Physici /Medic		1. Decedent's Name (First, Middle, Rita Denyel						2. Date of Dea Month MHRCH		2006	3. Time of Death
1	Examir		4a. Facility Name (If not institution, Saint Joseph	give street and number,  n Medical	Cen	ter	4b. City, Town, o	Location of Deal		4c. Count	y of Death Balt	imore
	Funeral Director		5. Social Security Number  218-74-3535  Usual Residence of Decedent	5. Sex 7. Ag 1 □ M 2 <del>Q</del> F	ge (In yrs. I 37	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year 968	9. Birthp Cour	place (State or Foreign htry) MD
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits
	Ba-f st	ctor	MD Baltin	١٥٢٤	r	Cowsor	1					1 ☐ Yes 2 ☐ No
	ath with the 23e or 2:	Funeral Director	10e. Street and Number 8415 Bellona				10f. Zip Code	21204		10g. Citizen of	What Cour	usa
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or items 23a or 28a-f show avent, the Medical Exeminar must be notified at	þ	11. Marital Status  New Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces: d 1 Yes 2 I If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba l □ Yes 2☑ No	Specify:		Specif	ce - Americ ck, White, fy: Bla	etc. 1Ck
<u>-</u> 2	n 72 h "natu	lete	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of B	Susiness/Ind	dustry Securit
212	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 2yrs	5+)		Contac			7 (	lmini	stration
Maryland		To Be C	17. Father's Name (First, Middle, La Isaac Allen					18. Mother's Na	me <i>(First, Middl</i> e, lia Mar	Maiden Sumar		
	s 1 and 2 should f Health and Meritem 27 is marke other traumatic	· ·	19a. Informant's Name/Relationship Cornelia Mari	e <del>Towns</del> A <b>llen</b>		504	g Address (Street a Chestnu	and Number or Ri t Hill	ural Route Numbe Ave Ba	r, City or Town ltimor	, State, Zip Ce MD	Code) 21218
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		DuĨ	aney aney anial	sition (Name of natory or other plac Valley Garden	4/	Date 5/06	20c. Location Timon	ium	MD
E D	permit. Departr Importa	i i	21. Signature of uneral Service Lie	Lavi		5 2	Name and Address 40 Reis	stersto			Fur ore M	neral Homo ID 21215
			23a. Part / Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	d the death ine.	n. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory are	rest,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ d			YPOGLYC	EMIA, H	IYFOTHEF	RMIA		Onset and Death FEW HRS.
	Examiner			Due to (or as								DEVE
	פ פ	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
()	death certificate be executed e attending physicien and ad for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. METAS Due to (or as			CREATIC	CANCER	<u> </u>			19 MOS.
68/60,	g phys as the	edical		d								
O. BOX	at the death certific by the attending p tached for use as i	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3 [	Ectopic pregnancy Other (specify)				ite of delive onth	ery Day Year
 J	requires that the reen signed by th hould be detache	y Ph	Part II. Other significant condition	s contributing to death b	ut not resu	ılting in the un	iderlying cause give	on in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
ecords	w requires that been signed to should be deta				<del></del>				1 □ Y	es 2 No	3 🏻 Prob	ably 4 Unknown
Lec	The law ete has b page 2 si	Completed							24a. Was a autop: perfor	med?	prior to cor death?	psy findings available inpletion of cause of
VITA	Physician: this certific rat director,	o Be	25. Was case referred to medical examiner?	Hospital:	V	FD/0	3 DOA Othe	26. Place of Dea		ne)		
_	gr jag	-	1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investigal	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ıry	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4   Indishing	ome 5 Resident			0
DIVISION		Certification;	3 Suicide 6 Could not 4 Homicide determine	be One Diese of les	ury - At hor c. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Numb n, State)	oer or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical (	29a. Certifier (Check only one)  Certifying  Continue  Continue  Certifying  Continue	Physician: To the best aminer: On the basis o and manner st	r examinati	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place pinion, death occu	, and due to the c irred at the time, d	ause(s) and ma late and place,	anner as st and due to	ated. the cause(s)
)	To the To the Complet	Σ	29b. Signature and little of certifier	31/16	1	111)	29c. License		Ž	29d. Date signe	d (Month,	Oay, Year)
	h	-	30. Name and address of person wh					760 No. 1		ļ		
	Sta	te_	31. Date filed (Month, Day, Year)	32 Registr	OSLE ar's Signat		VE #409	TOWSON	I, MARYL	AND 2	1204	
	Registr		MAR 3 1 2		. 1		All I					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item# 23a, PH 277, pen/F (854, 4/4/06 Tr)
State of Maryland'/ Department of Health and Mental Hygiene Timothy Avery 06-2129 AKG 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) , 2006 Year March 27, **Physician** 7:56 A M limothy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Sinai Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2 □ F 213-86-213-86-845 Usual Residence of Decedent Yrs. Director Naryland with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28a-f show The Medical Examinar must be notified at 1 XYes 2 □ No by Funeral Director MI altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 360 Park SA filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Never worked 12 unemployed . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ limothy Avery Janice torlune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
eny injury or other trau Balto. md. 21216 Mrs. ANNIE ark Ave Hamm oresi 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State armel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. rvice Licensee 22. Name and Address of Facility Funera W. North Ave, Baltimore h d. Truss 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diabetic ketoacidosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the Funeral Director. ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the el d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cocaine use 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? death? 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ty⊒Yes 2 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident i Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Extended Course of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SILAK 32. Registrar's Signature

ORIGINAL

O.C.M.E.

21201 111 Penn Street, Baltimore, Maryland

March 27, 2006

			1- For State of Maryland / Department Certification	nt of Health and M te of Death		iene	6 09898
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mildred Leona Adkins		2. Date of Dear Month	Day	Year 25 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City	, Town, or Location of Death	1111211	4c. County o	f Death
	t			ltimore or 1 Year   If Under 24 Hrs.	8. Date of Birth	N/	9 Birthplace (State or Foreign
	Funeral Director		217-18-5210 1 M 2X0 F 82 Yrs. Months	Days Hours Min.	Dec. 26	Year)	Maryland
	yland 10w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-fst	ector	Maryland Baltimore Ba	ltimore			1 ☐ Yes 2 No
	3a or 2	i Dir	100. Street and Number 101. Zi	p Code 21237	1	og. Citizen of Wi U.S	-
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Exercitient and be notified at	by Funeral Director		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
00-10	'2 hour hatural'	ted b	3 X Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usu  (Continue of the Continue l Occupation	·	16b. Kind of Bus		
1215	within 7 ane. Ihan "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12th Grade  (Give kind of we life. DO NOT L. Supervis	ork done during most of worki use retired)	ing	Fodonal	Government
d 2	be filed with stal Hygiene ad other tha evant, me	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I		
Maryland 21215-0036	should b and Ments marked umatic e	은	Theodore Ellion	Marie s (Street and Number or Rura		Bollinge	
, Ma	and 2 she alth and 127 Is ma			am Court, Bel			
ore	ges 1 and of He		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Na cemetery, crematory or				City or Town, State
altimore,	permit. Pages 1 and 2 Department of Health ar Important: If Item 27 Is any injury or othar trau		'4 □Donation 5 □Other (Specify) Oak Lawn Ceme 21. Signature of Funeral Service Licensee 22. Name a	etery $4/1/2$			e, Maryland Homes
Ö	Per la la la la la la la la la la la la la	. 11	Dictance Ruckers 9705	Belair Rd., B	altimore	2, MD 21	236
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	multiple	in respiratory arm	est,	Approximate Interval Between Onset and Death
	Examine be executed bhysician and sthe burial-transit	dicai Examiner		MCOICAL EXAMICA	\ <u>\</u>		
.O. Box 6	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date Mont	of delivery h Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant continuous continuous to death but not resulting in the unarrying	bollation		oacco use contrib es 2□No	robably 4 Unknown
α.		Completed	Pressure Sores Sepsis		24a. Was a autops perform	ned? pri	ere autopsy findings available for to completion of cause of ath? Yes 2 No
Vital	sician s certifi lirector	To Be	25. Was case referred to medical examiner?	26. Place of Death		ence 6 ⊡Other	(Specify)
Division of	ding Phy I. After this funeral c				28d. Describe ho	w injury occurre	
Divis	afte Dir	Certification:	Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factor willding, etc. (Specify)	y, office	28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number, DALL AM
	To the Hospital or within 24 hours afte To the Funeral Dirr completely filled in I	edical (		at the time, date and place,	and due to the cared at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
ı	To the within 2 To the complet	M		1c. License number			(Month, Day, Year) 28, 2006
	16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- Als D		17121	
	Sta	ite	31. Date filed (Month, Day, Year) 39. Registrar's Signature	ethe tal	70: / /d	-16121	2
	Registr		31. Date filed (Month, Day, Year)  MAR 3 1 2006  32. Registrar's Signature				

DHMH 17 Rev 1/2001

RANK AURIEMMA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer Physician 00 PM ARTHUR 2006 BOYCE MARCH HOWARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGONIERV

9. Birthplace (Stale or Foreign Country) 5. Social Security Number + HOSPITAL
7. Age (In yrs. last birthday) ADVENTIST Takawa Year If Under 24 Hrs. Park If Under Months 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) Hours 1 □ M 2 □ F Yrs. Director 578-20-7905 1061 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at VA King George 1 ☐ Yes 2√ No Colonial Beach Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Mimosa Ave 22443 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 □Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Repairman 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Hindle Boyce Hazel Elizabeth Dentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Reese/daughter 113 Windcliff Rd. Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any Injury or once. 03-31-2006 Beltsville MD 4 □Donetion 5 □Other (Specify) Chesapeake Crematory 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 annam 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** poension disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner orrales Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine led by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed 2 Chos resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No After this certificate has 2 No 1 ☐ Yes 1 Tes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🔯 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No death. 2 Accident М investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padma Chirumamilla 7600 Carroll Av Takoma Park MD 20912 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		Ľ	1 - State Registrar	State of Maryland / D )	epartment of H Certificate of I			giene Reg. No.	006	09901
I	Physici		1. Decedent's Name (First, Middle, Last)		BAI	2	2. Date of De. Month	Day	Yeer 1, 2000	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give str  5. Social Security Number  189-34-0481  Usual Residence of Decedent	Kins Hospik	N Balt	If Under 24 Hrs. Hours Min.	1	4c. C	County of Death	
	Maryland -f ehow	tor	10a. State 10b. County	ork 10c. City, Town Yor	_					10d. Inside City Limits 1   Yes 2 No
	with the	Funeral Director	10e. Street and Number 458 W. Princess	s St.	10f. Zip Code 1 7 4	04		10g. Citiz	en of What Cou	untry? USA
936	72 hours after death with the Maryland "natural", or Items 23a or 28e-f ehow calcal Examinations the multilistical	by Funers	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2 \overline{S} No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: W]	
121	c * 5	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) Unknown	College (1-4or 5+)	Decedent's Usual Occup 'Give kind of work done o life. DO NOT use retired ICAVET	during most of worl	king		d of Business/lextile	ndustry
nd	should be filed withir nd Mental Hygiene. marked other than imatic event, the Mark	To Be Co	17. Father's Name (First, Middle, Last) Unknown		Cuver	18. Mother's Nam Vi	olet B		Surname)	
	Ith ar 27 is		19a. Informant's Name/Relationship (Type Donna Miller /		Mailing Address (Street 33 Derry					ip Code)
altimore,	pernit. Peges 1 ar Department of Hea Important: if Item any injury or othe once.		20a. Method of Disposition  1 Burial 2 Tormation 3 Red 4 Donation 5 Other (Specify)	moval from State   Crematery	Disposition (Name of crematory or other place tion Dire ce Cremat		Date 9/06		ation - City or 1	
Ball	Departition of the control of the co		21. Signatury of Funeral Service Ligensee		22. Name and Address 5240 Reis	terstow	n Rd B	alti		
	hysician /Medical		23a. Part1. Enter the disease, or complice shock, or beart failure. List only one Immediate Carse (Final disease or condition resulting in death)	Arrhuthm	Di	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Onset Approximate OOUS
Į	ficate be executed  State of the purial-transit  State of the purial-trans	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	rtery 1	liseasi	2			Years
	ath certi attending for use a	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23	3d. Date of delin	very Day Year
rds, P.	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions control Chronic Obstr	ibuting to death but not resulting in	the underlying cause giv	en in Part I. いろものらも	3/			the cause of death?
II Reco	The law recate has bee page 2 short	Completed					24a. Was autoj perfo		24b. Were aut prior to death? 1 ☐ Yes	topsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	spital: 1 Inpatient 2 ☐ ER/Out 28a. Date of Injury (Month, Day Year)	me of 28c. Injur	4 🗆 Nuising n	th <i>(Check only c</i> ome 5 ☐ Resi 28d. Describe	dence 6		rify)
Divis	el or Atter s after des el Director ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office		28f. Location ( City or To		Number or Ru	ral Route Number,
	he Hospit in 24 hour he Funere pietely fille	Medicai (	(Check only 2 Medical Examine one)	cian: To the best of my knowledge, or: On the basis of examination and and manner stated.	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
•	To T Com	×	29b. Signature and the of certifier	MEDICAL RESIDE	29c. Licens				signed (Month	
	2		30. Name and address of person who com Ryphy TEDFURS, MID.	pleted cause of death (Item 23a) (1	Type, Print)  NWOIFE	H, BA	Himo	RE. I	MARYLAN	17,2006 UD 21287
	Sta Registr		31. Date filed (Month, 'Day, Year)  MAD 3 1 2	Sz. Houstian a digitatore	Leady	, -	, ,	/	,,,,	

_			For State Registrar	State of	f Marylar	nd / Depa	artmen rtificate			and M	lental H	/giene		6	09902
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of D Month			Year	3. Time of Death
	/Media		MARGARET				1				March				6:00 A M
4	Examir	er	4a. Facility Name (If not institution, g				4b. City,		Location of			40	. County o	f Death	
	Funeral		Good Samaritan 5. Social Security Number 6.			. last birthday)	If Under	1 Year	timo If Under:	re 24 Hrs.	8. Date of B	irth		9. Birth	place (State or Foreign
	Director		215-05-6967	1 □ M 2 💢 F	93		Months	Days	Hours	Min.	8. Date of B (Month, D Dec. 23	ay, Year,	2	Mar	place (State or Foreign ntry) yland
	ъ.		Usual Residence of Decedent		1										
	larylan ehow	2	10a. State 10b. County		10c. C	ity, Town or Lo									10d. Inside City Limits 1 XYes 2 No
	the Maryla 28a-fehor	Funeral Director	MD 10e. Street and Number			Balt	imore					40. 0			
)	with la or i	ä		- J			10f. Zip		220			10g. CI	tizen of W		ntry?
	death	era	5914 Glenkirk Ro	12. Was Dece	dent Ever in U	J.S. 13.	Was Deced	212 ent of His		gin? (Spe	cify Yes or N	0~	USA 14. Race		can Indian,
ယ	after or Iter		1 Never Married 2 Married	Armed For	rces? 2 <b>X</b> Xo					, Puèrto	cify Yes or N Rican, etc.)		Black	, White,	etc.
03	ral', c	d by	3 ₩Widowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2	X) No	Specify:				Specify:	WI	nite
5-0	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-1 ehow int, tra Midical Examinar must be notified at	Completed	15. Decedent's l (Specify only highest g			(Give	dent's Usua kind of wor	k done d	urina most	t of worki	ng	16b. K	and of Bus	iness/Ir	dustry
121	within ane. than	m	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	,				Cav	alie	r Sh	oe Polish
2	be filed withintal Hygiene. Id other than event, the M	ပ္သို	12 17. Father's Name (First, Middle, Las	it)			Bookk	.eepe		r's Name	(First, Middl				Comp.
an	e da b	To Be	August G								ine Zor			,	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ira M.	F	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a			l Route Numi		or Town, S	State, Zij	o Code)
			Richard Barlage-	Son							Roseda.				
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other the once.		20a. Method of Disposition	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		Place of Dispo	osition (Nam	ne of ther place	9) /	-1-	ate				own, State
<u><u>Ĕ</u></u>	mit. Page artment o ortant: If injury or e.		1 Surial 2 Cremation 3 4 Donation 5 Other (Spec		New	Cathedr	al Cem	etery	4	-1-	00	Bal	timo	ore	,Maryland
Salt	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	ensee		22	2. Name and	d Addres	s of Facilit	y EVA	NS CH	APE	L OF	ME	MORIES
	707 # 0		Condral his	ME for	Sden					<u>Roa</u>	d-Par	kvi.	lle,	MD	21234
	Priysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final)	y one cause on ea	aused the dea		1	of dying	such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Du to (	or as a conse	( A contract of ):	The	M G		(				-	Tiole Thou
	Examiner		Conversiolly lies and distance	He	1 RU	leis	whi	j							3 Hours
	(⊅ .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (	as a conse	quence of):									
V	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dunto	or as a conse	ula									
8760	ate be execute hysician and the burial-trans	ai E		Due to (	or as a conse	quence oi):									
687	ate hys	dicai		d								_			
Box (	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	ancy							23d. Date	of deliv	erv
B.	death e atte	iciai	in the past 12 months?	4☐Pregna	irth 2 ☐ Feta ant at time of a		⊒Ectopic pre ∃ Othe <i>r (sp</i> e						Mon		Day Year
P.0	t the by the tache	hys	9 Unknown	9□ Unkno	wn										
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco	use contri	oute to t	he cause of death?
ord	w requir been si should	ted		<u>.</u>		<del></del> -					1 🗆	Yes 2	□ No :	3 🔲 Prot	pably 4 Unknown
Vital Records,	elawı hasbı pe 2sh	Completed									24a. Wa auto	DSV	24b. W	ere auto	ppsy findings available impletion of cause of
H		Con									perf 1 ☐ Yes	ormed? 2₩No		ath? Yes	21X No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	1926		(Check only				
of	Physicia r this cert ral direct	- T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time o		A Bc. Injury	4 KINU	-	ne 5 ☐ Res 28d. Describe				(y)
OU	th. th: : After s funer	tion	1 Natural 5 Pending 2 Accident investigati	(Monti	h, Day Year)	Injury	м	Work	? ′es 2 □ l			now inju	, , , , , , , , , , , , , , , , , , , ,	-	
Division	Attending Physician: if death. ector: After this certificaby the funeral director, I	ifica	3 ☐ Suicide 6 ☐ Could not determine	286. Place	of Injury - At h	nome, farm, str	reet, factory.	office		12				r or Rura	al Route Number,
Ö	tal or s afte al Dir	Certification:	4   Homiciae	buildin	ng, etc. (Speci	iry)					City or To	wn, State	9)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying F	hysician: To the miner: On the ba and mann	isis of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time	cause(s date and	) and man d place, ar	ner as s	tated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Tu	qua	eui.	290.	License	number 6	1		29d. Da	te signed	(Month)	2006
	15		30. Name and address of person who	completed cause	e of death (Ite	m 23a) (Type.	Print)	- 91	'd-	2	123	7.			
	Sta		31. Date filed (Month, Day, Year)  MAR 3 1 20		egistrar's Sign	ature	di a								
	Registr	ar	INVIEW T CO		ACD AS	1 10000									

MARgaret, BARLAge

Physician /Medical Examiner

attending physician

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signed

peeu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28e-f show

Directo

Funeral

þ

Completed

ir then "neturel", or items 23e or 28e-f shor the Medical Examiner is ust be notified at

death 1

filed within 72 hours after

Pages 1 and 2 should be filed w thent of Health and Mental Hygien tent: If Item 27 is marked other ti jury or other treumetic event, ID.

permit. Page Department f Importent: If any injury or once.

Baltimore, Maryland 21215-0036

Box 68760,

as the use jo director, page 2

Examiner Physician/Medical þ Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death

Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. filled in by the funeral after death 24 hours a To the Hosp within 24 ho To the Func State

> Registrar THINK STOKE SHOULD

death.

Medical

2 Accident 3 🗌 Suicide 4 | Homicide 29a, Certifier

1 X Natural

1 ☐ Yes 2 🔀 No

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation in my ocition death. | Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

5 Pending

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work?

2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

29c. License number

D0061652

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performe

1 Yes

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

2K No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

# 750 Cliston MD 20735

address of person o completed cause of death (Item 23a) (Type, Print) 9131 PISCATAWAY RD MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

2006

		•	For State Registrar	State of Ma	aryland			nt of H te of L		nd M		giene 0		09905
	Physici /Medio		1. Decedent's Name (First, Middle, Las	ANNA	H. BU	SICK					2. Date of Dea Month March	27, 200		3. Time of Death 9:30 A M
	Examin	er	4a. Facility Name (If not institution, give 409 East Fort A	venue				Balti					/A	
85,	Funeral Director	8	5. Social Security Number 212-05-8567 6, S Usual Residence of Decedent	ex 7. Age ☐ M 2[x]F	98 (In yrs. la	st birthday) Yrs.	Months	or 1 Year Days	Hours	Min.	8. Date of Birth (Month, Day 0.ct 15	/, Year)		place (State or Foreign intry) cryland
	Maryland	tor	10a. State 10b. County Maryland N/A		10c. City,	Town or Lo	ocation	Ba1	timor	e				10d. Inside City Limits 1 X Yes 2 ☐ No
	th with the 23a or 28e	ai Director	10e. Street and Number 409	East Fort	Avenu	e	10f. Z	ip Code	2	1230		10g. Citizen ol W USA	hat Cou	intry?
5-0036	ours after dea ral', or Iteme	by Funerai	11. Marital Status  1 Never Married 2 Married  3 📆 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N II Yes, Give Year or Dates:				edent of Hi ecify Cuba 2 <b>K</b> No		jin? (Spe Puerto F	crfy Yes or No- Rican, etc.)	14. Race Blac Specify.	k, White	ican Indian, , etc. 1ite
21215-0	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Iteme 23a or 28e-f ehow event, I'm Medical Exam an must be multiled at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8	lucation de completed) College (1-4or 5	+)		kind of w DO NOT	ual Occupa ork done d use retired maker	luring most )	of workir	ng	16b. Kind of Bu		
Maryland	0 = 0 >	To Be (	17. Father's Name (First, Middle, Last)  T  19a. Informant's Name/Relationship (	heodore Hu	dnet	19h Mailir	an Addres	ss (Street s	J	ulia	Gerh	Maiden Sumam nardt v. City or Town		ip Code) 21146
altimore, Ma	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 le marked any injury or other traumatic e once.		Mary Joan Clopei	Niece Removal Irom State	20b. Pla		McK	insey ame of other place	Park	Dri	ve, Uni	t 104 Se	ever	na Park, Md
Baltin	permit. P. Departme Important any injury once.		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	<u> </u>		r 22	Name a	ind Addres	s of Facility	ak F		Home, P		, Haryrand
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Discations that caused one cause on each ling a.  Due to (or as a b.	10.	Do not ent	er the mo	de ol dying	g, such as c	cardiac o		rest,		Approximate Interval Between Onset and Death
8760, ×	ate be executed thysicien and the burial-transit	lical Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d										
P.O. Box 6	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal o	death 3	Ectopic Other (s	pregnancy specify)				23d. Date Mor		very Day Year
	The taw requires that the tee been signed by the bage 2 should be detache	by	Part II. Other significant conditions o	ontributing to death bu	ut not resul	ting in the u	nderlying	cause give	en in Part I.				ibute to	the cause of death?
al Reco		Completed									24a. Was a autop perfor 1 🗌 Yes	rmed?	Vere autorior to coleath?	opsy lindings available ompletion of cause ol
Division of Vital Records,	ing Phy After this uneral o	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner ol Death  1  Natural 5 Pending investigation	Hospital:  1  Inpatie  28a. Date ol Injur (Month, Day		R/Outpatier 28b. Time of Injury		28c. Injury Work	er: 4 🗌 Nur	rsing Hon		ne) lence 6  Othe low injury occurr		ify)
Divis	Ital or Attendi rs after death. el Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, farm, str	reet, facto	ry, office		2	281. Location (S City or Tow		er or Ru	ral Route Number,
	To the Hoepital of within 24 hours at To the Funerel D completely filled in	Medical	(Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examination	ledge, deat on and/or in	vestigatio	n, in my of	oinion, deat	d place, a h occurre	ed at the time, o	date and place, a	and due	to the cause(s)
	*	<	29b. Signature and tide of certifier				1	9c. License	Y O			3 /2 7	Month	/
-	10	· a	30. Name and address of person who  Dr. Marc S. Post  31. Date liled (Month, Day, Year)	er. M.D.	1147	S. Ha	nove	r St.	, Bal	timo	ore, Md	. 21230	)	
	Sta Registi			32. Pegistra	as A	K A	VB OSE							

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 0 9 9 0	16
	Physici: /Medic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 8: 00 1	Death ANM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth  Months Days Hours Min. (Month, Day, Year)  Yrs. Hours Min. (Month, Day, Year)	Foreign
	aryland show	7.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City  MA DOLLMARP	
	vith the M or 28a-f	Directo	106. Street and Number  106. Street and Number  107. Zip Code  109. Citizen of What Country?	
ဖွ	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heatht and Menthal Hygiens. Item 27 Is marked other than "natural; or items 23e or 28e-f show other traumatic event. It e Medical Examiner must be notified at	/ Funeral Director		
5-003	72 hours natural', iical Exa	eted by	3 Widowed 4 Divorced Year or Dates:	
21215-0036	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Water all the DO NOT use retired Water all the DO NOT use retired Water all the DO NOT use retired Water all the DO NOT use retired was all the DO NOT use retired to the DO NOT us	
Maryland	2 should be filk and Mentat Hy Is marked oth Bumatic event	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
	1 and 2 sho Health and am 27 Is ma		19a. Informant's Name/Re ationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3800 BEIVERER AVE. BAHMORE, MD 21215	
Baltimore,	0 0 = 5		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  RIVER (ALL PAYK CYCMATON) March 31, 2006  RIVER (ALL PAYK CYCMATON) March 31, 2006  RIVER (ALL PAYK CYCMATON) March 31, 2006	
Balti	permit. Pag Department Important: any injury o		21. Signatur Tuneral Service Licensee  22. Name and Address of Facility  James E. Lincoln Functal Home P.A. Baltimore, ND	21201
	Physician	(	23a. Part 1. Exter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Final	een eath
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  SE 12 UPE	<u>~</u>
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	B
8760,	sate be executed obysician and the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequence of):  d.	
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 1  Month Day Yes	ear
9	ires that t signed by d be detad	by	Part II. Other significant containing to death but not resulting in the underlying cause given in Part I.	
of Vital Records,		Completed	24a. Was an autopsy performed?  1 Ves 2 No 1 Ves 2 No 1 Ves 2 No	
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1   Yes	
ion o	anding Phy ath. rr: After thi		27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   No Injury at Work?	
Division	tal or Atta s after de al Diracto	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	e <i>r</i> ,
	To the Hospital or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Medical (		
)	To th	M	29b. Signature and title of certifier  Marita MITEMD  29c. License number  AT 2438 946  Nayon 22, 2006	
	İ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) May ita Mike 201 East University Parkway Union Memorial Hospital	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2006  MAR 3 1 2006	

State of Maryland / Department of Health and Mental Hygiene 116 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0635 *Margaret* 2006 Warch /Medical Examiner 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Harford Lorien - Bel Air Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 4, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕶 F Maryland 88 213-03-6326 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28a-f show other treumatic event, its Medical Examinar must be notified at 10d. Inside City Limits by Funeral Director 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21015 1909 Emmorton Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itel 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Produce Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August Phillip Bertling Esther Larkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 ts m any injury or other treurr once. 2703 Franklinville Road Joppa, Maryland 21085 Michele A. Schnell- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 3/31/06 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Heather Cain 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical signed by the attending pld be detached for use as i IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à ATRIAL FIBRILLATION, 1 Yes 2 No 3 Probably 4 Unknown been CONCESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? STROKE 2 No 1 Yes 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 622 S. UNIONAVE, HAWRE DE GRACE, MD21078 31. Date filed (Month, Day, Year) State Registrar

				1- For State of Maryland / Department of Health and M Certificate of Death		iene og. No.	9908
_		Physic /Medi	cal		2. Date of Deat Month	30 2006	3. Time of Death 2-50A M
.160		Funeral	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  ALT MORE WASHINGTON MEDICAL CENTRAL SUFFORM SUFF	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
Zat		Director	70	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10-5-	37 TEN	10d. Inside City Limits 1 □ Yes 2 ☑ No
7		death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	10e. Street and Number  10f. Zip Code  21/261	1	0g. Citizen of What Cour	
negro	5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 Is markad other then "natural", or Itams 23a or 28e-f shov other traumatic event, the Medical Examiner must be rodified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sipecify Cuban, Mexican, Puerto  1 Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Q	21215-0	filed within 72 hours after Hygiene. kther then "natural", or Ita snt, I'n Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life, DO NOT use retired)  MANAGER  MANAGER	ing	16b. Kind of Business/In	dustry STATE
	Maryland	2 should be filed withir and Mental Hygiene. Is markad other then aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  SANDA		Maiden Sumame)	
		as 1 and 2 shool Health and 1 item 27 is m. r other traum			ENBLEN	EMD. 2	1061
		Page nent o ant: If ury or		20a. Method of Disposition  1  Burial 2 Gremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  4  Donation 5 Other (Specify)	Date	20c. Location - City or To	own, State
	Balt	permit. Pag Department Importent: I any injury o		21. Signature of Fure all Service Licenses  22. Name and Address of Ficility Day therty Family Funeral Hom 2601 Mountain Road			
		Physician		PM1. Enter the disease, complianons the caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one are so on each line.  Immediate Cause (Final disease or condition	or respiratory arre	est,	Approximate Interval Between Onset and Death
		/Medical Examiner  ohysician and the purial-transit	ical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			2/2012-2012
	P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   State		23d. Date of delive Month	ery Day Year
	ds, P.	uires that signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the	
	of Vital Records,	ician: The law requir certificate has been si rector, page 2 should l	Completed		24a. Was ar autops perform 1 Yes 2	y prior to cor death?	psy findings available npletion of cause of 2 \( \square\$ No
	f Vita	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		e) ince 6 □Other (Specify	()
	Division o	Attending Phy death. ctor: After thi y the funeral	ertification;	27. Manner of Death  1		w injury occurred	,
	Divis	ital or Att irs after de rel Directo led in by t	O	4 Homicide building, etc. (Specify)	City or Town		
	:	To the Hospital or within 24 hours after To the Funerel Dire	edical	29a. Certifier  (Check only one)  1 ★ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a control of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	tuse(s) and manner as st ate and place, and due to	ated. the cause(s)
	)	To the company of the	W	29b. Signature and title of certifier  29c. License number  10 45 649		Pd. Date signed (Month, I	
		8 8		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sci Abyto 30 i Hospital Drive Ghen Bom	rnie r	nd 210	61
		Sta Registr	476	31. Date filed (Month, Day, Year) MAR 3 1 2006  MAR 3 1 2006		~.	

Amend item# 10e, perFH, 1854, 4///6 TT State of Maryland / Department of Health and Mental Hygiene () () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year MARCH William Beverly : 15 76 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) Days Hours 1□**火**M 2□F Director Yrs. 220-36-0819 65 Jun 11, 1940 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f ehover on the province of the contract of the contribution of th Funeral Director Maryland N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3535 Dudley Avenue 21213 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö ar then "neture!", or Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Charter Bus **Bus Driver** of Health and Mental Hygiel fitem 27 le marked other tir other traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonso Beverly ဥ Martha Beverly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Beverly Wife 3535 Dudley Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Pimportant: If ite any injury or of once. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/01/06 Windsor Mill. Md. King Memorial Park 21. Si puttire of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or head failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NTERSTITIAL 20 415 LUNG /Medical Due to (or as a consequence of): Examiner MPHYSEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit HEART ONGESTIVE Due to (or as a consequence of): 68760, ORONARY Physician/Medical HEART IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death P.O. I 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 3 Probably Be Completed 1 ∏Yes 2 ∏No 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificete has t irector, page 2 s Division of Vital 2₩No 1 Yes Hospital or Attending Physiclan: 24 hours after death. funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending neral Director: A filled in by the fr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATZ438946 FI5 MARCH, 26 2006 lacha la 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 HALA MEMORIAC HOSPITAC MAC UNION 31. Date filed (Month, Day, Year) MAR 3 32. Registrar's Signature State 2006 Registrar

24 6 7 7 7 7 1 6 1	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of Month		Day	Year	3. Time of Death
Physici /Medio		Patricia Ann Bratch								March	28,			3:30 p
Examir	er	4a. Facility Name (If not institution, give	street and numb	er)				Location of	of Death			4c. County	of Death NA	
		Joseph Richey Hospice  5. Social Security Number 6. Se	9X 7.	Age (In vrs.	last birthday)	If Under	Ltimo	re If Under	24 Hrs.	8. Date of I	3irth			place (State or Forei
uneral irector		217-66-5036	□M 2 <b>X</b> )F	47	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, 09–30–1	958	ear)	Mary	place (State or Forei ntry) land
M III		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside City Limit
important: if item 27 is marked other than "naturel", or items 23a or 28a-f ehow eny injury or othst traumatic event, the Medical Examiner must be notified at once.	ţ	MD NA			В	altimon	re							1 XYes 2 □ N
1 2	irec	10e. Street and Number		1,		10f. Zip	Code				10g	. Citizen of	What Cou	ntry?
238	ai D	1926 Sherwood Avenue					21218	8				USA	A	
iner m	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 \( \text{Yes} \) 2	s?						ecify Yes or Rican, etc.)	No-		ce - Ameri ck, White,	can Indian, etc.
Exe	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2	2X No	Specify:				Specif	Blac	k
ice	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usua kind of wor	l Occupa	ation furing mos	t of work	ana	16	b. Kind of B	usiness/In	ndustry
2	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired, sewi.fe	)		9		Domest	tic	
를	CO	12				nous	SEMIT		or's Nom	e (First, Midd	10 140			
• •	Be	17. Father's Name (First, Middle, Last)								Mae Red			ne)	
matic	၉	Wylie Robinson  19a. Informant's Name/Relationship (7)	vne Printi		19h Mailir	na Address	/Street a			al Route Nun			State Zir	n Codel
trau	h [	George Bernard Bratcher				-				ltimore,			State, 24	, ,
other		20a. Method of Disposition	. 01/ 50!!	20b. P	Place of Dispo					Date		c. Location	- City or T	own, State
y or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ILE	itus Mem				4-01-	-06	Ba	ltimore	e. MD	
	l i	21. Signature of Funeral Service Licen		7232.00		2. Name and							,	
Duc		humerla	Jones	)	W	ylie F	unera	1 Home	638	N. Gilm	or S	St. Bali	timore	, MD 21217
detached for use as the burial-transit	icai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):									
sched for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1⊟Live birth 4⊟Pregnan 9⊟Unknowi	t 2 ☐ Feta t at time of d	Ideath 3[	Ectopic pre							te of deliventh	ery Day Year
should be deta		Part II. Other significant conditions co	ontributing to deat	h but not res	ulting in the u	nderlying ca	ause give	en in Part I				cco use cont		the cause of death?
	Completed										as an topsy rforme		Were auto prior to co death?	opsy findings availabl impletion of cause of
U.										1 Tes				2□ No
	Be	25. Was case referred to medical examiner?	Hospital:				Othe			th Check on	-	1		Hasla
8	tion: To	1 Yes 2 1 16  27. Mann of Death 1 Venatural 5 Pending 2 Accident investigation	1 ∐ Inpo		28b. Time of Injury		Bc. Injury Work	4 🗆 NU		ome 5 ☐ Re 28d. Describ				m)Hospice
	Certification:	3 Suicide 6 Could not be determined	200. Place of	Injury - At ho	ome, farm, str	eet, factory	, office			28f. Location City or			per or Run	al Route Number,
8	edical C	29a. Certifier 1 Vertifying Physics (Check only one) 2 Medical Exam	/sician: To the be iner: On the basi and manner	s of examina	wledge, death	n occurred a	at the tim in my op	ne, date an pinion, dea	nd place. ath occur	and due to the	ne caus e, date	se(s) and ma	anner as s and due t	stated. o the cause(s)
comptetely fille			unu mamilei	J.U.OU.							.,,04	Data sissa		
ompietely fille	Med	29b. Signature and title of certifie	0 /			29c	License	number			290	. Date signe	d (Month,	Day, Year)
completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifie	) ) /	) M		290		030	,			_		5, 2006 ·

DHMH 17 Rev 1/2001

2/22/26

Patriera Bratcher

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Mar 27, 2006 2:14 p Thomas M. Boone /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore Baltimore** Catonsville Commons 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 💢 M 2 🗆 F Director Jan 14, 1927 So. Carolina 250-36-3102 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23e or 28e-f show any or other traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore Director Maryland N/A 10e. Street and Number 10g. Cilizen of What Country? 10f. Zip Code U.S.A. 5129 Sekots Road 21207 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black δ Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearl Clark Sam Boone 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 771 Yale Avenue Baltimore, Maryland 21229 Starola Sparrow Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 03/31/06 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the el 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No should t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 20 No 2 \( \text{No} \) 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: : After this certific e funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 136942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Cefarguille, MD 2/228 MD · TURAJONIA 1009 frederick 31. Date filed (Month, Day, Year) 32. Pristrar's Signature State 1 2006 Registrar

Registrar DHMH 17 Rev 1/2001

State

DE 60

31. Date filed (Month, Day, Year)

BALTIMORE

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21230

BELT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELARD

2006

1401

32. Registrar's Signature

an	Registrar		Ce	rtificate of	Death		Reg. No.	
	Decedent's Name (First, Middle, La Margie Ann Ches:	,				2. Date of De Month	Day 26, 20	Year 3. Time of Death 1:00P
cal ner	4a. Fecility Name (If not institution, given	ve street and number)		4b. City, Town, o	or Location of Death		4c. Count	
	411 Kenmore Ave	nue Apt.	6		Bel Air		Harf	ford
		Sex 7. Ag 1 □ M 2 Kg F	e (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	th ay, Year) 5/1942	9. Birthplece (State or Foreign Country)  MD
	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
to	MD Harfor	rd	Bel Air					1 □ Yes 2 🗷 No
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
	411 Kenmore Aver	nue		21014			USA	
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4  Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	Ńo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specif	ce - American Indian, ack, White, etc. fy: White
Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	pation during most of work d)	ing	]	Business/Industry
d l	Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use retired emaker	d) -		Own He	ome
	11 17. Father's Name (First, Middle, Last	<i>*</i>	МОН	emaker	18. Mother's Nam	a (First Middle	Maiden Sumar	ma)
To Be	William Monk	,			Rena W		,	
	19a. Informant's Name/Relationship (	(Type, Print)	19b. Maifi	ng Address (Street	and Number or Rui	ral Route Numb	er, City or Town	, State, Zip Code)
	Flora Cook/Sister	r	276	Cree Ter	rrace Dri	ve Risi	ng Sun,	MD 21911
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci  21. Signature of Funeral Service Lice	fy) nsee	Bel Air	Memorial  Name and Addre  Cremation	LGardens	al Alter	Bel Ai	- City or Town, Stete  r, Maryland  re, Maryland
edical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Finaf disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. Due to (or as	a consequence of): a consequence of): a consequence of):	lung	Cance			Approximate Interval Between Onset and Death  Common to
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf death 3	Ectopic pregnancy Other (specify)	у			ate of delivery onth Day Year
Ď	Part fl. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.		obacco use con Yes 2 □ No	itribute to the cause of death?
Completed						24a. Was	an 24b.	Were autopsy findings available prior to completion of cause of
E O						autor perfo	rmed?/	death?  1 □ Yes 2 □ No
BeC	25. Was case referred to medical examiner?				26. Place of Deal	- '	,	
10	1 Yes 2 No	Hospital: 1   Inpatie	nt 2 ER/Outpatier		4   Nursing no	me 5 Resi	dence 6 Oth	her (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	y Year) 28b. Time o	Wor	y at rk? Yes 2 □ No	28d. Describe	how injury occur	rred
Certification:	3 Suicide 6 Could not be determined	building, etc				City or To	wn, State)	ber or Rural Route Number,
- 1	29a. Certifier (Check only one) 1 € Certifying Pl	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and made,	anner as stated. and due to the cause(s)
ledicai					a a combana		Od Data siese	
Medica	29b. Signature and title of certifier	1-	<i>-</i>	29c. Licens	548 H	/	3/2	27/06

DHMH 17 Rev 1/2001

		_	State of Maryland					-	_	ne. Na bool	1 1.
		1 - For State Registrar				of Deat			∠, U U ig. No.	10 0331	1 65
Physi	cian	1. Decedent's Name (First, Middle, Last)	0 . \					Date of Death     Month	Day	3. Time of D	_
/Med	lical	4a. Fecility Name (If not institution, give s	Corkran		Ab City T	own, or Location	as of Dooth	03	30 a	1000 12:10	J M
Exam	iner	RC= DCIK Crest L				ielin=			Ba	lhove	
Funera Directo		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Months	Year If Und Days Hour	der 24 Hrs. s Min.	8. Date of Birth (Month, Day, June 5,	<sup>Year)</sup> 1908	9. Birthplace (State or F Country) Maryland	roreign
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City	Limits
Maryl -f eho	ţō	Maryland Baltimore		Parky	ville			1		1 □Yes 2	. ⊠ No
h the	irec	10e. Street and Number			10f. Zip C	Code		10	g. Citizen of \	What Country?	
ath wil	rai	8832 Walther Blvd	to the second se		212				USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Exercical must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ul>	11		nt of Hispanic y Cuban, Mexi X No Spec		ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. v: White	
-00-	ed	15. Decedent's Educ	ation	16a. Deced	lent's Usual	Occupation			16b. Kind of B	usiness/Industry	
215 hin 72 Med.	piet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life. [	kind of work OO NOT use	Occupation done during no retired)	nost of work	ing			
21.	Con	12		Dress	smaker			(FT) - A471// A	Seamst		
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)  George W. Wolf						e (First, Middle, A Dixon	Maid <b>e</b> n Suman	ne)	
aryla should ind Men s marke	ို	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	a Address (				City or Town,	State, Zip Code)	
Ma nd 2 s alth ar 27 is r treu		Frank G. Lidinsky	Attorney							land 21286	
of Hear		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re		ace of Dispo	sition (Name	e of ner place)	1	Date :	20c. Location -	City or Town, State	
Page ment ant: If		4 □ Donation 5 □ Other (Specify)	Met	ro Cre			4/1/2			ille, Maryl	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Oppartment of Health and Mental Hygiene. Important: If them 27 is marked other than "neture!", or any injury or other treumetic event, the Madical Exam		21. Signature of Funeral Service License	alsocat	W 18	Tunera 530 Ed	.1 Home mondso	of Ca n_Aver	itonsvil. nue: Cato	le, Inc onsvill	chwab Witzk e, MD 21228	
Physicia		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line.	. Do not ente	er the mode	of dying, such	as cardiac	or respiratory arre	est,	Approximate Interval Betwee Onset and De	een
/ /Medica Examine		resulting in death)	Due to (or as a consequ	ience of):							
	e e	Sequentially list conditions, if any, reading to immediate	Dua to (or as a consequ	iánca of).							
60, be executed icien and burial-transit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
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0 00		0									
Box (eath certification of the astending for use a	In/M	23b. was decedent pregnant	3c. If yes, outcome of pregnal		Ectopic pre	gnancy				te ol delivery	
- D m D	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown		Other (spe				Mo	onth Day Ye	ar
IS, P.O.	by Ph	Part II. Other significant conditions con	tributing to death but not resu	ılting in the ur	nderlying car	use given in Pa	art I.	23e. Did tot	acco use con	tnbute to the cause of dea	ath?
cords w requires been sign should be	ed b	CVA averniz						1 □ Y€	s 2 No	3 ☐ Probably 4 ☐ of	known
Records, the law requires to that been signed age 2 should be	Completed							24a. Was a autops	V	Were autopsy lindings av	railable use ol
	Соп							perform 1 ☐ Yes 2		death? 1 ☐ Yes 2 ☐ No	
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor		h (Check only on			
Of Phys	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		c. Injury at	Nursing Ho	ome 5 Reside			
Attending of death.	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2	No				
Division of si or Attending Phy safter death. I Director: After this d in by the funeral d	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory,	office		281. Location (St City or Town		ber or Rural Route Numb	91,
Division of To the Hospitel or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or in-	occurred a vestigation,	t the time, date in my opinion,	and place, death occur	and due to the cared at the time, d	ause(s) and mate and place,	anner as stated. and due to the cause(s)	
To th withir To th comp	M	29b. Signature and title of certifier			29c.	License numb	er	2	9d. Date signe	d (Month, Day, Year)	
		a factor			D	0030	977	1	3/30	po	
2		30. Name and address of person who	inpleted cause of death (Item	23a) (Type,	Print)	4 17:11	f 1			•	
3(4) 30	****	31, Date liled (Month, Day, Year)	2 Augistrar's Signar	ture d	K Cle	s) (111	my -				
Regi	state str <b>ar</b>	MAR 3 1 2006	Blown A	100	ALL S		-				

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Physician Medical Examiner  Charles  D. R.  Collins  Collins  As Facility Name (if not institution, give street and number)  Funeral Director  Funeral Direc	oreign Limits
Funeral Director  Funeral Dire	oreign Limits
Social Section   Number   Social Section	_imits
Usual Residence of Decedent  10a. State 10b. County MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10d. Inside City L MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 11g. May Decedent of Hi	_imits
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Charles Bagley-Son 1505 Montpelier Street, Baltimore, Md 212	□ No
Charles Bagley-Son 1505 Montpelier Street, Baltimore, Md 212	
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Charles Bagley-Son 1505 Montpelier Street, Baltimore, Md 212	
Charles Bagley—Son 20h Place of Disposition (Name of Data 20h Location City of Data 20h Location	
1 Burial 2 ©Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 3/31/06 Baltimore, Md	718
22. Name and Address of Facility  March F/H West	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart hature. List only one cause on each line.  Approximate Interval Between	9n
Physician Immediate Cause (Final disease or condition Immediate Cause (Final disease or condition I day	
Examiner  Due to (lor as a consequence of):	7
if any, leading to immediate  Due to (or as a consequence of):	]
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Pennon de training cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	
Second to the past 12 months?  1   Second to the past 12 months?   1   1   1   1   1   1   1   1   1	
The first conditions continued to the conditions continued	ır
Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of the ca	.L2
236. Did tobacco use contributing to death but not resolving in the underlying cause given in Part I.	
1   Yes 2   No 3   Probably 4   No    1   Yes 2   No 3   Probably 4   No    24a. Was an autopsy performed? death?   1   Yes 2   No    1   Yes 2   No   3   Probably 4   No    24a. Was an autopsy performed? death?   1   Yes 2   No    1   Yes 2   No   3   Probably 4   No    24b. Were autopsy findings ava prior to completion of caus death?   1   Yes 2   No    1   Yes 2   No   3   Probably 4   No    24b. Were autopsy findings ava prior to completion of caus death?   1   Yes 2   No	ailable se of
performed?   death?   1   Yes 2   XNo   1   Yes 2   No	
25. Was case referred to medical examiner?  1   Yes   2   XNo   Hospital:	
27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Pending 28c. Injury at Work?  28d. Describe how injury occurred Work?	
Comparison of the control of the c	r.
27. Manner of Death   28d. Describe how injury occurred	
Second   S	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
Resident Doctor P 19509 March 25 20	06
Resident Doctor P 19509 March 25 200  Atl Masan O2 degirmenci 900 Caton Avenue Baltimore MD 212	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	29

			CROCKETT									
1	06-02021 RKD		Pleas Unpend item# 23a	e Type or Pri	nt in Blac	k Inde	lible Ink	. Ensure A	II Copies	Are	Legible.	
	IGD		1 _ State	State of W	larytand /		ተient of I ficate of		Mental Hy	giene	2006	ngola
١			Registrar  1. Decedent's Name (First, Middle,	Last)	-	Certin	cale of	Dealli	2. Date of De			3. Time of Death
	Physici /Medio		MICHAEL	TYRONE	CRO	CKETT			MARCH	22	2, 2006	1:12P. M
	Examir		4a. Facility Name (If not institution,		)			or Location of Death	1		. County of Deat	
7	Funeral		NORTHWEST HOSPI'		ge (In yrs. last bi	rthday) If	ANDALL Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		BALTIMOR 9. Bird	nplace (State or Foreign
3	Director		439-17-8205	1⊠M 2□F	39	Yrs. Mc	onths Days	Hours Min.	Aug 26	$\frac{1}{2}$ , $\frac{1}{2}$	966 L	A
	riand ow		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Tov	n or Location	on					10d. Inside City Limits
	e Many e-f eh	ctor	MD Baltin	nore	Gwyn	n Oak	-					1 ∰Yes 2 ☐ No
	with the or 28	Funeral Director	10e. Street and Number	_		1	Of. Zip Code 2124	. /.		_	tizen of What Co USA	untry?
	death me 23	erai	2507 Molton War	12. Was Deceden		13. Was		Hispanic Origin? (Sp an, Mexican, Puerto	Decify Yes or No		14. Race - Ame	
900	Ours after	þ	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2 1  If Yes, Give Year or Dates:	? -No	1	s, specify Cub Yes 2∰ No		o Rican, etc.)		Black, White Specify: B1	
045	BAITIMORE, MARYIANG Z1Z13-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or itame 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinat must be notified at ance.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) Cotlege (1-4or	5+)	(Give kind life. DO N		during most of world)	king		ind of Business/	ndustry
Č	G Z filled v Hygie other t	ပို	12 17. Father's Name (First, Middle, L	ist)	Co	orrect	ions 0	18. Mother's Nam	ne (First, Middle,		rison	
	Vian uld be Mental rrked c	To Be	William D. Cro	ckett				Bernadi	ine Robi	nson.	n	
	Aary 2 sho 2 and 2 1 s ma		19a, Informant's Name/Relationshi	(Type, Print)	191	o. Mailing Ad	ddress (Street	and Number or Ru	ral Route Numb	er, City o	or Town, State, Z	ip Code)
9	1 and Heelth Heelth tem 27		Geneva Crocket  20a. Method of Disposition	:/Wife	20b. Place o	f Disposition	n (Name of	enue, Bak	cer, LA	707 20c. Le	714 ocation - City or	Fown, State
	Pages Pages nent of int: if i	3	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spi		Port Nation	io, crematoi Hudson na 1	ry or other pla 1	<sup>сө)</sup> ¦ March	31.06	Zac	chary, L	Α
=======================================	Baltimore, permit. Pages 1 an Department of Heel Important: if item; eny injury or other		21. Signature of Funeral Service Li	cens + 7			me and Addre	ess of Facility Ca				
1			23a Part 1 Fotor the disease or o	July Mu	elle d the death Do			Street,			≥, LA 7	0807 Approximate
	Physician	0 5	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	Arteriosc					or respiratory a	11031,		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	d	s a consequence		J. Carrier G	130030				
	Examiner	7	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying	b.	a cultaquence	-0						
	cuted nd ransit	aminer	cause (Disease or injury that initiated events	20010 (01 4	a consequence	01).						
ç	e exection and urial-tr	Ä	resulting in death) Last	Due to (or as	a consequence	of):						
2000	physic s the b	dica	•	d						_	_	
7	VISION Of VITAL MECOIDS, P.O. BOX 08/00, Attending Physicien: The law requires thet the death certificate be exe death. scitor: After this certificate has been signed by the attending physicien a ty the funeral director, page 2 should be detached for use as the burial-	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	۰.					23d. Date of deli	very
	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death		opic pregnanc ner (specify) _	y			Month	Day Year
0	JUISION Of VITAL MECOLIGS, P.O. or Attending Physician: The law requires thet the defined death.  Director: Alter this certificate has been signed by the in by the funeral director, page 2 should be detached.	/ Ph	Part II. Other significant condition	s contributing to death	but not resulting	in the underl	lying cause gr	ren in Part f.	23e. Did t	obacco i	use contribute to	the cause of death?
100	quires quires an sign uld be	(q pa	Obesity						10	Yes 2	□No 3□Pro	bably 4 Unknown
0	eco law re as bee 2 sho	Completed							24a. Was		24b. Were au	topsy findings available ompletion of cause of
2	al H : The cete h : page								perfo	rmed? 2 □ No	death?	2 No
V::	VIII sician scertifi	To Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 ER/O	stantiont 3	X DOA Ott	26. Place of Dea			2	
ď	ng Phy ter this	J: L	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b.	Time of Injury	28c. fnjui Wol		28d. Describe		6 □Other (Spec ry occurred	ny)
	ISIOI Mtendir death. ctor: Al	catic	1. ⚠ Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion		٨	M 1 🗆	Yes 2□No				
	Hospital or Al 24 hours efter of Funeral Directely filled in by	Certification;	4 Homicide determin	ad 289. Place of in	jury - At home, fa tc. (Specify)	arm, street, f	factory, office	and the state of t	28f. Location ( City or To			ral Route Number,
	UNISION OF VICAL HECOIDS, P.O. BOX 58 fou, To the Hospital or Attending Physician: The law requires that the death certificate be executing the steer selected and the second solution of the funeral Director. After this certificate has been signed by the attending physician are completely filled in by the funeral director, page 2 should be detached for use as the buriat-	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medical E.	Physician: To the best aminer: On the basis of and manner s	of examination ar	e, death occ nd/or investig	curred at the tig gation, in my o	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s date and	) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0 - 1 0			29c. Licens				te signed (Month	
	A V		Courte	reall)	d - 4 - 4	·		.M.E.		MARC	H 23, 20	006
	0'		30. Name and address of person w	Completed cause of	death (Item 23a)			N STREET	BALTIMO	RE,	MARYLAN	21201
	Sta Registr		31. Date filed (Month, Day, Year)	39. Regist	rar's Signature							
			MUK 3 1 4	JUU LANGE								

		•	For State 1 - State Registrar	te of Marylan		artment <i>tificate</i>			nd M		giene Reg. No	000	0991	7
4			Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Da	v Year	3. Time of	Death
4 -	Physici /Medic		HELEN M. CRAWFORD							MARCH	29,	2006	7:30	РМ
	Examin		4a. Facility Name (If not institution, give street a			4b. City, To		ocation of	Death			. County of Death		
100	, y.Y.,	<b>*</b> .	763 OLD DONALDSON AVE		and himbolays	SEVEI		If Under 2	4 Hrs.	8. Date of Bir		INE ARUNI		r Foreign
	Funeral		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. I	Yrs.		Days	Hours	Min.	(Month, Da	ıy, Year)	1930 MAR	place (State o ntry) ΖΤ.ΔΝΠ	roreign
	Director		Usual Residence of Decedent	,,,						IMIN. Z	, .	LJJO IIIIK.	LEAND	
	yland		10a. State 10b. County		, Town or Lo	cation							10d. Inside Ci	
	a-f	ctor	MARYLAND ANNE ARUNDEL	SE'	VERN					- 1			1 🗌 Yes	2 JAI NO
	or 28	Oire	10e. Street and Number			10f. Zip C						tizen of What Cou		
	ath w 23e	Funeral Director	763 OLD DONALDSON AVE		C 112.1	2114		annio Orio	in2 (Cno			ED STATE		
	after deat or Iteme	n.	Am	s Decedent Ever in U. ned Forces?  Yes 2 X No	5.	f Yes, specif	y Cuban	, Mexican,	, Puerto F	cify Yes or No Rican, etc.)	, I	Black, White,		
36	irs aff		v If Y	es, Give ar or Dates:		1 □ Yes 2(	X No	Specify:				Specify: WHI	ГЕ	
21215-0036	72 hours after death with the Maryland naturel', or iteme 23e or 28e-f show Jisal Examiner must be mailled at	Completed by	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece	dent's Usual kind of work	Occupat	tion uring most	of workin	na	16b. K	ind of Business/Ir	ndustry	
21.5	within 7 ene. than "r he wed	npie		lege (1-4or 5+)	life.	RY WOI	retired)				MAN	IUFACTURI	NC	
	be filed within 72 hours after death with the Marylan at Hygiene.  de Hygiene.  de they than "naturel", or Items 23a or 28a-f show event, the Maulical Expiritive must be invitilled at		1Z		FACIO	KI WUI		18 Mother	r's Name	(First, Middle			.NG	
pur.		Be	17. Father's Name (First, Middle, Last)  JAMES G. DICK							IARIE B				
Maryland	s 1 and 2 should f Health and Mer frem 27 is marke other treumatic	2	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailir	na Address (						or Town, State, Zi	o Code)	
Ma	id 2 s lith an 27 is treu		JACQUELINE L. CRAWFOE									MD 2114		
ē,	of Healitem		20a. Method of Disposition	C	lace of Dispo	sition (Name	e of ner place	)		ate	20c. L	ocation - City or T	own, State	
Ë	Pages nent of int: If it		1 ☐ furial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Denation 5 ☐ Other (Specify)	trom State	N HAVE			· A	2006	, 3,	GLE	N BURNIE	, MARY	LAND
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Engeral Services Consee	,	22 K 4	Name and IRKLEY 21 CRA	Address Y-RUI AIN	of Facility DDICK HWY.,	FUN S.E	ERAL H	OME, N BU	P.A. URNIE, MI	21061	
i de	* 3		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death e on each line.									Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	Meta	8+	ati	(	-	> <	2xc	2/	29	Onset and I	رريون
	/Medical Examiner		resulting in death)	ue to (or as a consequ	uence of):	- 0	1	N	1-	201			20	h
	Examiner	L	Sequentially list conditions, b.	Que to (or as a consequ	/ / / / / / / / / / / / / / / / / / /	~	7) 0			70)			× ~~	607
abla	bed isit	nine	cause. Enter Underlying Cause (Disease or injury	12 a R	derice or).	~	9	Aa	N	ani	1	4	3 ms	dus
	be executed Icien and burial-transit	Examiner	that initiated events c	oue to (or as a consequ	uence of):	•		<u> </u>		1			/	<u> </u>
8760		icai	<b>L</b> d	lung	- ~	-es	-0	No	os	10			44	Ray
9	tificat ig phy as the					_		-					1 0	
Вох	death certificate e attending phys id for use as the	an/N	23b. was decedent pregnant	es, outcome of pregna ]Live birth 2 □ Fetal	incy I death 3	Ectopic pre	gnancy					23d. Date of deliv	,	Year
	it the deal by the att tached fo	Physician/Med	1 Ves 2 No	Pregnant at time of de Unknown		Other (spe	cify)					Worth	Day	Tour
P.0	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing	ig to death but not resi	ulting in the u	nderlying car	use giver	n in Part I.		23e. Did	tobacco	use contribute to	the cause of c	leath?
Records,	uires tha signed ild be del	d by	<u>Petroper</u>	1 to	ee	1 5	sa	Y UX	2~0	10	Yes 2	No 3□Pro	bably 4 🗆	Jnknown
00	w requir s been s should	Completed			حا	7 1	99	9		24a. Was		24b. Were aut	opsy findings	available
Re	0 - 0	E O			/					auto perfe 1 ☐ Yes	psy ormed? 2 <b>™</b> No	death?	ompletion of c 2□ No	ause oi
Vital		a l	25. Was case referred to medical					26. Place	of Death	(Check only	_/			
<b>&gt;</b>	N S	To B	examiner? 1 Yes 2 No Hospital	1 npatient 2	ER/Outpatier			4   Nui	rsing Hor	ne Kas	idence	6 ☐Other (Spec	fy)	
n of	ding Ph I. After th funeral	on:	27. Manner of Death 28a.	Date of Injury (Month, Day Year)	28b. Time o Injury		Sc. Injury Work			28d. Øescribe	how inju	ry occurred		
Sio		cati	2 Accident investigation 3 Suicide 6 Could not be	. Place of Injury - At ho	omo form st	M dadan		es 2□		28f Location	Street a	nd Number or Rui	ral Route Nurr	her
Division	or A after Direct	Certification:	4 Homicide determined	building, etc. (Specify		eet, ractory,	onice		1	City or To			a	50.
_	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier Check only 2 Medical Examiner: On											s)
	ths H hin 24 the F nplete	<b>dedicai</b>	one) an	d manner stated.	tion and or in									
	Twith Co.	Σ	29b. Signature and title of certifier			290.	License	2	95	141	1. DE	ate signed (Month	3155	ODL
	10			ed aguage of design (IV)	22a) (T:	Drint)		7 7		1)	1	Iarun	7 - 1	
	Įυ		30. Name and address of person who complete		234) (1996,	7 10	7.00	is h	₹.	Has	100	7 217	2	4
2	Sta	ate	31. Date filed (Month, Day, Year)	32. Projestrar's Signa	iture	Locale	, -							
1	Regist		MAR 3 1 2006	Jan Har	15 1									

Physici /Medio		1. Decedent's Name (First, Middle, La	st)	Ce	rtifica	te of l	Death	2. Date of I	Reg. No.		3. Time of Death
		LAURA S. DAVI						March	Day	2006	4:40 P
Examir		4a. Facility Name (If not institution, give University of Maryle	and Medical	<del></del>	130	iltim	Location of Dea		4c.	County of Death	1
Funeral Director		5. Social Security Number 6. S 220-76-8184  Usual Residence of Decedent	Sex 7. Age (	(In yrs. last birthday) 62Yrs.	Months	Days	If Under 24 Hr Hours Mir		Day, Year) 194	9. Birth Con	nplace (State or Fore untry) MD
natural', or Items 23a or 28a-f show dical Examinar must be notified at	or	10a. State 10b. County  MD Harford		Bel Air							10d. Inside City Limit
r 28a-	rect	10e. Street and Number		DEI AII		ip Code		_	10g. Cit	izen of What Co	untry?
23a c	ralD	114 Brightoaks I	rive			2101	L5			USA	
ital Hygiene. Ind other than "natural", or Items 23a or 28a-f ahow event, ine Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖰 Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Dece If Yes, sp 1 ☐ Yes		ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	
n "natura	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed)	16a. Dece (Give life.	dent's Usi kind of w	uaf Occupi rork done d use retired	ation during most of w	orking	16b. K	ind of Business/I	ndustry
al Hygiene. other than " vent, ine Mac	Com	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	homen	naker					own hor	ne
and Mental Hygis is marked other aumatic event, II	To Be (	17. Father's Name (First, Middle, Last Charles Gordo				,	18. Mother's Na Berth	ame (First, Midd a Hel		Sumame) Thamert	
Ith and 27 is m r traum		19a. Informant's Name/Relationship (Charlotte Mozingo			-		and Number or F KS Drive			Town, State, Z D 2101.	_
nent of Hea int: if Item iry or other		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Disponentery, cre CHESAPEA	matory or	other plac		Date 30/2006		ocation - City or 1 $1$	
Depertment of any injury or once.		21. Signature of Funeral Service Lice	gsee M	100986			on Facility Ohen D. 1 Pastur			wson, M	
hysician and paraletransit as as the burial-transit as as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or a) Due to	consequence of):	rt fi	ailur	r				Onset and Death  Months
e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. ff yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetaf death 3	⊒Ectopic (					23d. Date of deli Month	very Day Year
pe de	þ	Part II. Other significent conditions	contributing to death but	not resulting in the u	underlying	cause give	en in Part I.		d tobacco u	_ \_	the cause of death?
ste h page	Completed							24a. W au pe 1 🗆 Ye:	topsy rformed?	prior to death?	topsy findings availal completion of cause of
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	2 ☐ ER/Outpatie	nt 3□ D	Oth	20	eath (Check on		S Cother (See	u.E.o.l
After	<del> </del>	27. Manner of Death  12. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			28c. Injun Worl		28d. Describ		6 □Other (Spec y occurred	iny)
s after dea il Director id in by th	Certification:	3 Suicide 6 Could not be determined	(Street an		ral Route Number,						
within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Exe	nysician: To the best of miner: On the basis of e and manner state	xamination and/or ir	th occurrencestigation	d at the tin	ne, date and place pinion, death occ	ce, and due to the	ne cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
To the comp	W	29b. Signature and title of certifier	2 4 .1		1	9c. Licens				te signed (Monti	
1		30. Name and address of person who	completed cause of dea	tth (Item 23a) (Type	, Print)	P194				ch 22,	2006
Sta		Susannah Batko-Y 31. Date filed (Month:-Day, Year)	OVNO, M.D.  32. Begistrar		reene	st.	Balhr	norg M	1D 2	1201	

	State of Maryland / Department of He State of Maryland / Certificate of D	eath eath Reg. No. 06 09919
Physiciar /Medica Examinei	1. Decedent's Name (First, Middle, Last)  Helen E. Dean  4a. Facility Name (If not institution, give street and number)  Ab-City, Town, or L.  MARYLAND GRENE AL LOSD FAL BOLLING.	ore Crty
Funeral Director	214-20-8048 1 M 2 F 87 Yrs. Months Days	If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign MD)
B Maryland	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore City Baltimore	10d. Inside City Limits 1 ★ Yes 2 □ No
th with the Mar 23a or 28a-f s ist ba notified	10e. Street and Number 10f. Zip Code 21217	10g. Citizen of What Country? United States
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It flow 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event. The Medical Examinar must be notified at To Ba Completed by Europa Director.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  Spec
d 21215-0036 (iled within 72 hours af Hygiene Hygiene Hygiene Hygiene Hearther than "natural", or mot, the Mazical Exami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Waitress	on 16b. Kind of Business/Industry Hospitality
Maryland 2 A Should be filed to 2 Should be filed to and Mental Hygile to an arked other traumatic event.		8. Mother's Name (First, Middle, Maiden Sumame) Unk Unk
Ce, Maryla 1 and 2 should Health and Men tem 27 Is marke other traumatic		d Number or Rural Route Number, City or Town, State, Zip Code) ourt Baltimore, MD 21231
P P P P P	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  Chesapeake Cremator	
Balt permit. Departn Imports any inju		of Facility 1 Funeral Alternatives astures Drive Baltimore, Maryland 21286-
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the action of the a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Conset and Death
that the death certificat of by the attending phy detached for use as the physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery  Month Day Year
rdS, P. quires that an signed build be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Records, sicien: The law requires t certificate has been signe frector, page 2 should be Re-Completed by		24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
on of ting Phys.  After this funeral d	Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other.  27. Manner of Death 1 Impatient 2 EP/Outpatient 3 DOA Other.  28a. Date of Injury (Month, Day Year) Injury  28c. Injury a Work?	4 Nursing home 5 Nesidence 6 Dother (Specify)
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Madrical Certification.	2 Accident investigation 3 Suicide 6 Could not be determined elemined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)
Div To the Hospital or A within 24 hours after To the Funeral Dirs completely filled in b.	29a. Certifier (Check only one).  1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	, date and place, and due to the cause(s) and manner as stated.  ion, death occurred at the time, date and place, and due to the cause(s)
To To To To I	29b. Signature and title of gertifier  TALAL KHAIRI MD 89	29d. Date signed (Month, Day, Year) 558 3/27/06
7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Tacal Kharki M. D. D. Maryb  31. Date filled (Moruth, Day, Year)  32 Registrar's Signature	nd General Hospital
State Registrar	MAR 3 1 2006 Street & April 2	

ORIGINAL

20	1	For State Registrar	State of	f Marylai	nd / Depa	artmei	nt of H	lealth and	Mental Hy		enn 6	09920
Physician /Medica	n	1. Decedent's Name (First, Middle, Donald Walter De							2. Date of D Month March	eath Da		3. Time of Death 7:05 P. M
Examine Funeral	r	4a. Facility Name (If not institution, g Gilchrist Hospic	nive street and num		. last birthday) Yrs.		TOW:	r Location of Dea SON If Under 24 Hr Hours Mir	s. 8. Date of B	40	: County of Dea	
		Usual Residence of Decedent  10a. State 10b. County	ore Coun	10c. C	ity, Town or Lo				Jan 2	J , L J Z	23   Ba.	10d. Inside City Limits 1 Yes 2 No
GC C	Funeral Director	10e. Street and Number 210 Ridgely Road	l					1093		Ur	tizen of What C nited St	
DOJ 0036 ours after rai', or ite	2	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	Armed Fo.	2 No W.T		Was Dece If Yes, spe 1  Yes	* *	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N irto Rican, etc.)	lo-	14. Race - Am Black, Wh Specify:	
Ind 21215-C ind 21215-C be filed within 72 h all Hyglene. d other than "natu	Completed	15. Decedent's (Specify only highest (Secondary (0-12)	Education grade completed) College (1	I-4or 5+)	16a. Dece (Give life.	kind of w	ial Occup ork done ise retired nkin	during most of w d)	orking		and of Business	Vindustry Vational Bank
ind ind ind ind ind ind ind ind ind ind	10 06	17. Father's Name (First, Middle, La Elmer DeHaven		' C- \	1			Maude I				
De ha		19a. Informant's Name/Relationship Mrs。 Phyllis (nee 20a. Method of Disposition 1 □ Burial 2 哲Cremation 3	Ritchie	e) DeHave		Rid	gely	Road I	Pural Route Number of Pural Route Number of Pural Pura	,Mary		21093
Baltimore, Misperiment of Health a limportant: If them 27 is eny injury or other tra		4 Donation 5 Other (Spe	cify)		ans Fur	neral	Cha	pel 20	006			ill,Maryland ion Ctr.,P.A. 21093
System of the british transit	Calexa	23a. Phys. Enter the disease, or construction of the construction	a	aused the dea ach line. Should be (or as a consecto	quence of):	ter the ma	de of dyin	g, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68 or attending Physician: The law requires that the death certificate her been signed by the attending physician director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it is attitication. To Be Completed by Physician Landwidth	iysiciani/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 Fet	al death 3[	⊒Ectopic p □ Other (s					23d. Date of de Month	llivery Day Year
cords, P	<u>`</u>	Part II. Other significant conditions	s contributing to de	eath but not re	sulting in the u	nderlying	cause giv	en in Part I.		tobacco Yes 2	ر	o the cause of death?
Vital Record licien: The law requir certificate has been s rector, page 2 should		25. Was case referred to medical						OS Place of D	24a. Wa autr perf 1 Yes	opsy formed? 20 No	prior to death?	utopsy findings available completion of cause of s 2 No
ision of Vi	0	examiner?  1  Yes 2 No  27. Manner of Death  PSNatural 5 Pending 2  Accident investigat	28a. Date of (Mont		ER/Outpatier 28b. Time of Injury		28c. Injun Wor	er: 4 ☐ Nursing	Home 5 Res	sidence	(-1	ocity) huspice
Division content of the state o	Ceruic	3 Suicide 6 Could not determine	ed 286. Place buildir	of fnjury - At h ng, etc. (Speci	( <b>fy</b> )				City or To	own, State	ə) 	lural Route Number,
Divisio  To the Hospital or Attendivitin 24 hours efter death.  To the Funeral Director: A completely filled in by the funeral Medical Certifical.	Medica	29a. Certifler (Check only one)  29b. Signature and fills of certifier	Physician: To the aminer: On the ba and mann	best of my kn asis of examin ner stated.	owiedge, deat ation and/or in	vestigation	c. Licens	ne, date and place pinion, death occurrence number	ce, and due to the curred at the time	29d. Da	d place, and du	e to the cause(s)
State Registrar	2	30. Name and address of person when Charles is 31. Date filed (Month, Day, Year)  MAR 3 1 2	m 6601	e of death (Ite	rorles à	St B			) 2/201			

				1 - For State Registrar		State	of Ma	aryland		artme <i>tifica</i>				Mental Hy	/gier	$a \cup U$	6	09921
		D		1. Decedent's Name (First, A	Viddle, La	st)		-						2. Date of D	eath	Day	V	3. Time of Death
		Physici /Medio		Ruth	Yvc	nne	Ι	ozie	r					March			Year 6	5:38 P M
		Examir		4a. Facility Name (If not insti			um <i>ber)</i>			4b. City	y, Town	n, or Loc	ation of Deat	h		4c. County	of Death	
		<u> </u>		Suburban								esda				Montg		<u> </u>
		Funeral		5. Social Security Number 224-46-3341	6. S	ex □M 2⊠F			st birthday) Yrs.	If Und			Jnder 24 Hrs. ours Min.	(Month, D	ay, Yea		9. Birth	place (State or Foreign ntry)
		Director		Usual Residence of Deceder	nt			68			<u> </u>			Jan. 2	25,	1938		VA
		yland		10a. State 10b. Co	unty			10c. City,	Town or Lo	cation								10d. Inside City Limits
		a-t-e	ctor	DC N	one			Was	hingt	on								1⊠Yes 2 No
		or 28	Olre	10e. Street and Number						10f. Z	ip Code	е			10g. (	Citizen of W	/hat Cou	ntry?
		ath w	by Funeral Director	3519 13th St	t., N						001					JSA		
		er de Items	nue	11. Marital Status		12. Was Dec Armed F	orces?			Vas Deci í Yes, sp	edent o ecify Cu	ol Hispar Juban, M	nic Origin? (S exican, Puert	pecify Yes or N o Rican, etc.)	0-		e - Ameri k, White,	can Indian, etc.
	36	irs off	J.	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		1 ☐ Yes If Yes, G Year or I	ive	10		I □ Yes	2 <b>X</b> N	No Sp	pecify:			Specify	: В1	lack
	21215-0036	2 hou		15. Dec	edent's Ed	ducation			16a. Deced	lent's Us	ual Occ	cupation			16b.	Kind of Bu	siness/In	dustry
	215	hin 7.	Completed	(Specify only h Elementary/Secondary (0-		de completed, College (		+)	(Give	kind of w DO NOT	rork dor	ne durine	g most of wor	rking				,
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	Maryland	be file tal Hy d oth	Be (	17. Father's Name (First, Mid										ne (First, Middle		en Sumam	θ)	
	yla	Men Marke Marke	၉	Augusta Smit										eth Brow				
	Mar	12 sh h and 7 le m raum		19a. Informant's Name/Rela			7.							ıral Route Numb			State, Zip	Code)
	e,	1 and Heattl Brm 2; ther i		Frances E. V	vasnı	ngton/S	SIST	The second second	16436 ace of Dispo				d., Mi	lford,		22514 Location -	Ciby or T	Num State
M	ğ	nt of I		1 ⊠Burial 2 □ Cremat			State	Ox f	metery crer ord M	natory or E Z	other p 1011	olace)	4/1/				•	
8	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours eller death with the Maryland Department of Heatth and Mental Hygiane. Important: If item 27 ie marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event. The Medical Examinar must be notified at once.		4 □Donation 5 □ Other 21. Signature of Funeral Ser				Bap	tist	Chur	ch			W. Edwa		ther		
	Ba	Dep Imp		Jasto		•								ng Green				nome
-				23a. Part1. Enter the diseas shock, or heart failure.	e, of com	plications that	caused	the death.										Approximate
	Æ	Physician		Immediate Cause (Final disease or condition	Lise only	one cause on	each iirii	θ.	SER									Interval Between Onset and Death
		/Medical		resulting in death)		a Due to	(or as a	conseque	ence of):								_	
		Examiner	. 1	Sequentially list conditions,		b			PA	160	M	01	NA					
2		sit ad	lner	cause (Disease or injury	1	Due to	(or as a	conseque	enea of;		٥.		A	ny				
O		tificate be executed ig physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last		c	/or as a	conseque	ORO	NA	RY	/ /	TREE C	RY	01	JEA.	56	
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	Вох	eath certiff attending for use as	Ž	IF FEMALE: 23b. Was decedent pregnan	,	23c. If yes, ou									8 7	23d. Date	of delive	erv
$[A_1]$	m.	death e atte od for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Mo		4☐Preg	nant at t	2 ☐ Fetal of time of dea		Ectopic p Other (s						Mon		Day Year
	Ö.	by the	hys	9 Unknown		9□ Unkn	nown											
4	s, I	Attending Physician: The law requires that the death certif r death. sctor: Atter this cartificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by F	Part II. Other significant con	ditions c	ontributing to d	death bu	t not result	ting in the ur	derlying	cause (	given in	Part I.	23e. Did	tobacc	o use contri	bute to t	ne cause of death?
+	Records,	w require been sign	ted											1 🗆	Yes	2.0 No	3 🗌 Prob	pably 4 Unknown
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/-	ō	Phys rthis ral dii	<u>۲.</u>	1 Yes 2 No 27. Manner of Death	1	110	Inpatien		R/Outpatien 28b. Time of		OA ID	4	☐ Nursing H	ome 5 Res				y)
(V)	ou	ding I h. After funer	턉	Natural 5 ☐ Pe	ending estigation	28a. Date (Mon	ith, Day	Year)	Injury	м	28c. Inj W		2 □No	280. Describe	HOW III	jury occurre	au .	
	Division	Attendir death.	fica	3 ☐ Suicide 6 ☐ Co	ould not be	28e. Place	e of Inju	ry - At hom	ne, larm, stre					28f. Location (	Street	and Numbe	r or Rura	I Route Number.
5	Ö		Certification:	4  Homicide de		build	ing, etc.	(Specify)						City or To	wn, Sta	ate)		
X		ospital or Attenhours after deathours after deathoneral Director: by filled in by the	cal (	29a. Certifier Cart	ifying Ph	ysician: To the	e best of	f my know	ledge, death	occurred	at the	time, da	ate and place	, and due to the	cause	(s) and mar	nner as s	tated.
[]		To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	55,		and man	ner stat	examinatio	or and/or in					rred at the time,				
		To To	Σ	29b. Signature and title of ce	rtifier	2	_ /.	3-	u i m			nse nun	571.	24		ate signed		
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		Registr		MAR 3 1	2006			8.0	GOOD	0								

State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 30 2006 **Physician** 12-45AM ANTHONY F. DELIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Baltimore Washington Wedical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUNE 13, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F **Funeral** 90 199-03-6027 1915 PENNSYLVANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other then "natural", or items 23a or 28s-f show traumatic event, the Mudical Examinant must be notified at MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 X No GLEN BURNIE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7840 BRUTON DRIVE 21060 UNITED STATES 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1943 – 1XXes 2 □ No If Yes, Give 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: WHITE Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 is marked other then \*n. College (1-4or 5+) Elementary/Secondary (0-12) PETROLEUM ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic evolution. ANTHONY J. DELIA MARY ANGELA BLUNDI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RAYMOND DELIA / SON 14483 139TH STREET OLATHE, KANSAS 66062 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State APRIL 1, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HOLY CROSS CEMETERY 2006 4 ☐Donatign 5 ☐ Other (Specify) YEADON, PENNSYLVANIA 21. Signatur Funeral Service Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME P.A. MD 21061
421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TASSIVE INTRACEREBRAL **Physician** /Medical Due to (or as a consequence of) Examiner PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and the burial-transit certificate be executed Exami and Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 2 No 1 Tes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Matural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier D45149 March MI 30. Name and a cress of person who co letted cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE GLEN BURNIE, MD B. ONABAJO, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Year GERALD DELIA MARCH 27, 2006 9:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE Baltimore City 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Yrs Director 213 50 7392 58 MAY 27, 1947 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2√No MARYLAND Directo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 Bruton Drive UNITED STATES 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Manager Restaurant other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 te marked othe any injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony F. Delia Pauline Allegra ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Delia / Brother 14483 W. 139th Street Olathe, Kansas 66062 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 1. 1X Burial 2 Cremation 3 Removal from State 5 Other (Specify) Holy Cross Cemetery 2006 4 Donation Yeadon, Pennsylvania 21. Signature of Funeral KTRKTEY-KUDDICK"FUNERAL HOME P.A. CRAIN HWY. S.E. GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com, if ations that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only the cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed attending physician end for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the at 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but for resulting 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 7 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes Z nerei Director: After this calliled in by the funeral dire ဥ 1 Depatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 10 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) License numbe 30. Name and address of who comp d cause of death (Item 23a) (Type, Print)  $\mathcal{O}$ I 32. Registrar's Signature 31. Date filed (Month, Day State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ross. PIDREXEL MAR 2006 0030 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAL TIMORE,
If Under 1 Year | If Under 24 Hrs MERCY MEDICAL CENTER MD Under 1 Year onths Days 5. Social Security Number If Under Months 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1∏M 2□F 215-34-9812 Director 69 Jan 18, 1937 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rthen "natural", or itema 23s or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1X Yes 2 □ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 124 W. Franklin Street #906 21201 USA unk 12. Was Decedent Ever in U.S. Armed Forces? 111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 14. Race - American Indian. unk Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk un. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene Important: If Item 27 ie marked other then "r any njury or other traumatic event, Ita Med 9056. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul Place Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ₩Other (Specify) in state 21. Signature of Funeral Service Licensee.

ROTIAL S. Wade Mile Coor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 3a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIC ENCEPHALOPATHY Physician DAYS /Medical Due to (or as a consequence of): Examiner DAYS COLITIS SCHEMIC Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ttending physicien and or use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death ce ifficate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dby 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 2 ☐ No Director: After this cerumd in by the funeral director, 25. Was case referred to medical examiner?
Yes 2 No Be 26. Pface of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending fnjury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and plane, and due to the course(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KROholakia. MAR 23 2006 D0063326 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUSH. DHOLAKIA, MERCY MEDICAL CENTER, BALTIMORE, MD
31. Date filed (Month, Day, Year)
WAR 3 1 2006 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item# 11,12,15,16a-d,17,18,20a-c,22, perFH, (854, 4/5/05 TT
State of Maryland / Department of Health and Mental Hygiene ) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rodel Month Year 31.14 A M 1) owns MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN MEDICAL LENTER ARUNDEL BUKNIE BALTIMOKE WASHINGTON ANNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk **Funeral** Months 15√2M 2□ F Director 212-80-1179 Yrs. 45 Jan 10. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r 28a-f show Show 10d. Inside City Limits 1 Yes 2 No Directo Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or itema 23a or Examiner must be 21401 13 6th Street USA Funeral Unk

12. Was Decedent Ever in U.S.Unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk 1 end 2 should be filed within Health and Mental Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Janitor Nursing Hone unk 11 th 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be Wilton Downs Eleanor Simus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Baltimore Wasington Medical Ctr 301 Hospital Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or ance. 4 Donation 5 Other (Specify) in state Metro Crematory 3/30/2006 Baltimore, MD State "Andres Morapolis Mo 21401 21. Signature of Suneral Son on Licensee Ade, Director min Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sopsis Physician /Medical Due to (or as a consequence of): Examiner Bilaleral pnyumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and s the burial-transit The law requires that the death certificate be executed HIV/AIDS Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Circhosis with been si 1 Tes 3 Probably 4 Unknown renal Failure acthy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has birector, page 2 s autopsy performed2 (es 2 No adidosis metabelic 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No by the f 2 Accident 3 Suicide 6 ☐ Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 000aa4f3 March 25, 2006 B MD MD 305 Nospital A. Glen Burnie, MD STURRET JAcoss 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 2006

DHMH 17 Rev 1/2001

TODEL TODEL

Downs

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Benjamin F. Edwards Sr. 12.35a.M 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Nursing Home Rockville Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth Augus Cay, 17, 1923 5. Social Security Number 547–38–4519 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **№** 2 🗆 F 82 Director Yrs. DeSoto County Usual Residence of Decedent Mississippi 10b. County 10a. State 10c. City, Town or Location Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examinar must be notified at 10d. Inside City Limits **Funeral Director** MD Prince Georges Bladensburg Yos 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5999 Emerson Street #209 20710 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 No1/22/43 If Yes, Give Year or Dates: 2/25/46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 2/25/46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Cab Driver Self Employed is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental William Edwards Ruby Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Nadine A. Rawls (Daughter) 12300 Needlepine Terr. Silver Spring, MD 20904 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Cemetery 3/27/06 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Austin de Royster Funeral Home 3821 14th Street NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myolardial /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of): Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗀 No of Vital 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO055362 3-16-06 120852 Konser Remanente 30. Name and address of person who completed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Mercia S. Sports 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗎 🦳 1- State Registra Amend Item #31 Per DVR C853 Sertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8:19 ам Charles Stratton Fessenden, Jr. March 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7900 Benesch Circle Apt 786 Anne Arundel Glen Burnie
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 → M 2 □ F Hours Yrs. **Director** 213-28-4126 75 Jan.11, 1931 Ohio Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel
10e. Street and Number Glen Burnie 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than """ any injury or other traumett. ō items 23a 7900 Benesch Circle Apt 786 21060 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ⊋ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Manufacturing Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Pearl Shivley Charles Stratton Fessenden, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Fessenden/Wife 7900 Benesch Circle Apt 786, Glen Burnie. Maryland 2060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □ Other (Specify) 04/03/06 Elkridge, Maryland Meadowridge Memorial Signature of Hun and Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Ave.Baltimore, Maryland 21229 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final disease or condition resulting in death) rostate Physician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funerel Director: After th
completely filled in by the funeral 28b. Time of Injury 27. Manner Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 1 tural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funerei To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03.3/.2006 D40491

State Registrar 31. Date filed (Month, Day,

2006 Bloom & Books

518 South Camp Meade Rd., Linthicum, Maryland 21090

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

2

Amend #27 penMF, 9869, 7/18/07 TT
Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item# 23a-c, PII 27, 28a-f, penMF, 9855 5/15/06 TT
ForAmend #19a Per Inf G861 11/28/08 JH
Registrer Nathaniel Finch 06-02118 crn 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FINCH March **Physician** 2006 NATHANIEL 3:43 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, **Funeral** Director 06-16 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits other then "natural", or Items 23s or 28s-f ehovent, the Modical Examinar roust be notified at 1 Yes 2 □ No Director SATTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 COL U.S.A. by Funeral filed within 72 hours after death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 D No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABOREK 1074 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 2 Is marked JAMES FLEMING FINCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FINCH Diana Bailey /9/0 of Health a AUE, HELEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate permit, Pages 1 Department of H Importent: If ite eny injury or ott Burial 2 Cremation 3 Removal from State CARMEL CEM. 04-01-06 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIP A. Weatherford Funeral Sor. 21. Signature of Funeral Service Licenses Mulle 2431 E. OLIVER ST. BACTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatic encephalopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Cirrhosis Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Chronic alcoholism and hepatitis C virus infection Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Complications of remote head trauma certificate has been si rector, page 2 should Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \( \subseteq \) No 24a. Was an autopsy performed? 2□No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TyYes 2 □ No 1 7 Inpatient 2 ER/Outpatient 3 DOA Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury all Work? 28d. Describe how injury occurred After 1 Natural 5 Pending efter death. 1 ☐ Yes 🔏 ☐Xvo investigation 10/24/2004 subject fell 2 Accident the unk 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) St. Paul Street Baltimore, MD filled in by 4 Homicide street within 24 hours e To the Funerel D completaly filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. March 27, 2006 mille 30. Name and address of person who completed caus ATRICIA WK w111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Re State Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Dep		of Health a of Death	ınd Menta	l Hygie	tion to the to	) (	9929
	g pu	, we	1. Decedent's Name (First, Middle, La	st)				2. Date Mon	of Death	Davis		3. Time of Death
	Physici /Medi		John	R.	Finne	erty		Mar		9, 20	<sup>7 өаг</sup>	3:30PM
	Examir		4a. Facility Name (If not institution, giv 1814 Jackson R	_			vn, or Location on ndalk			4c. County o		re
	Funeral		5. Social Security Number 6. S	ex 7. Ag <b>X</b> M 2□ F	e (In yrs. last birthday	If Under 1 Y   Months Da		24 Hrs. 8. Date Min. (Mor	of Birth	,1939 I	9. Birthpl Coun	lace (State or Foreign try)
- 4	Director		216-34-3223 Usual Residence of Decedent	**	67 Yrs.			Mar	ch 12	, 1939 <sub>1</sub>	Mary.	land
	how	_	10a. State 10b. County		10c. City, Town or L	ocation					10	0d. Inside City Limits
	8a-1	Funeral Director	Maryland Baltimo	ore	Dunda	alk						1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Cod			10g	. Citizen of Wh	at Coun	try?
	leath	era	1814 Jackson Road	12. Was Decedent	Ever in U.S. 13		1222	nin? (Specific Vec	or No.	USA 14. Race	Amorice	an Indian
36	be filed within 72 hours after death with the Maryland stal Hygiene. Indicate then "natural, or items 23a or 28a-1 show event, the Medical Exam and must be publical at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 11  If Yes, Give Year or Dates:	No	If Yes, specify (		gin? (Specify Yes , Puerto Rican, e	tc.)		White,	etc.
2-0	72 hou		15. Decedent's E	ducation	16a. Dece	dent's Usual O	ccupation	-1 -1:-	16	b. Kind of Bus		
21	within 7 ene. then "r he Med	Completed	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use re	one during most atired)	or working				
121	fygier tygier her th		12 years		Prog	rammer	1			Compute		
Maryland 21215-0036	ould be fi Mental H arked ot atic ever	o Be	17. Father's Name (First, Middle, Last, Gerald Finnerty				4	r's Name <i>(First, I</i> Cie Putte		den Sumame,	)	
ary.	d 2 should th and Men 7 is marke traumatic	To	19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (St		r or Rural Route		ity or Town. S	ate. Zio	Code)
	122 Ting		Kevin Finnerty	son								MD. 21236
Baltimore,	8 = 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Disp cemetery, cre Sacred Hear	osition (Name o matory or other Ct Of Jesi	of place) us Cem.	April 1,		. Location - C	_	
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Figheral Service Licen		2	2. Name and Acconnelly	ddress of Facility Y Funera	il Home (	Of Du	ndalk.	P.A.	
79			23a. Part1. Enter the disease, or com sheek, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of	dying, such as d	ardiac or respira	tory arrest,	ilulak, r		Approximate
	Physician		Immediate Cause (Final disease or condition		10-ath	erascle	erstic c	nedio.	JU DL	ا مردو	₹ .	Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
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Ī.	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
V	sicien and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as	a consequence of):						-	
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9		Medi	IF FEMALE:									
P.O. Box	thet the death certificate ed by the ettending phys detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregna □ Other (specify				23d. Date Monti		ry Day Year
	law requires thet the es been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause	given in Part I.	23e	Did tobac	co use contrib	ute to the	e cause of death?
ord	w require been si should t	ted	Hyperlipid	emia					1 Tes	2 □ No 3	☐ Proba	ably 4 Unknown
ecc	hes be ge 2 sh	Completed	Chronic re	nal ins	ufficie	ncy		24a	Was an autopsy	24b. We	re autop	sy findings available
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<u> </u>	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death (Check				
oţ	Phys r this aral di	. To	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outpatie	" 3 DOA	4 🗆 1901			e 6 Other		)
ion	Attending r death.	ation	1 Natural 5 Pending 2 Accident investigation		Year) Injury		njury at Work? 1 □ Yes 2 □ N		01100 1104 1	injury occurred		
Division of Vital Records,	al or Atte efter des i Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, st . (Specify)	reet, factory, offi	ice		tion (Stree or Town, S		or Rural	Route Number,
	To the Hospital or Attending Physician: whin 24 hours eller deals resemble. To the Funeral Director. Alter this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination and/or in	h occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to n occurred at the	o the caus time, date	e(s) and manr and place, an	er as sta	ated. the cause(s)
	To t	Σ	29b. Signature and title of certifier			29c. Lic	ense number		29d.	Date signed (		
1			mill	2- m	0	D3	333¢.	7		3131	10	6
	(()		30. Name and address of person tho				~ C+~	CC P	1		-	19-11
-8	Sta	te	MAURA M.C.u. 31. Date filed (Month, Day, Year)		r's Signature	PO3.10	on olk	EET B	HUTT	murb	2	1224
1	Registr		MAD 2 1	2006		beeter						
DHI	MH 17 Rev 1/20	001	T C AHIII	COULT PROPERTY	as so p							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frazier Phyllis 753M 2006 03 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAYVIEW Hopkins ohns BAUTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 69 219329765 Director 936 ano Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to I tam 27 is marked othar than "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Exeminer must be notified at MD Baltmore 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Avenue US 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Doivorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 6 MAS HOPKINS College (1/4005+) Elementary/Secondary (0-12) Frogram Coord NI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koland onno Danow 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State torest Hill, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Kuneral Chape 22. Name and Address of Facility Peaceful Alternatives and Cremation center 2325 york rd. Timonium, mp 210 21. Signature of Funeral Service Licensee cremation york rd mp 21093 endrae h. 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of ping, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deut Immediate Cause (Final disease or condition resulting in death) secondary to bowel prep **Physician** SCHEMIC DOWEL /Medical Due to (or as a consequence of): Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Division of Vital Records, P.O. Box 68760, Co the Hospital or Attanding Physician: The law requires that the death certificate be executed should be detached for use as the burial-transit signed by the attending physician and resulting in death) Last Due to (or as a consequence Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon 1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 1 🗌 Yes 2 🗆 No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tittle of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 3/24/2006 14806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greet BALTIMORE 600 NoAh MD 2/287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 8853 3-31-06 vt
State of Maryland 7 Department of Health and Mental Hygiene 1 6 1993

		•	For State State Registrar	Ce	rtificate of L	Death	Reg	ı. No.	
	2		Decedent's Name (First, Middle, Last)	-			2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Maude Irma F	isher			March 2		1:45 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
		水炼	114 Still Meadow Road		Joppa			Harfo	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 89	Yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Dec. 26	(ear) 9. Birth Coul	place (State or Foreign ntry) Siana
	pu 🛌	-	Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or L	ocation				10d. Inside City Limits
	sho	5	Total States						1 ☐ Yes 2 🏧 No
	the N	Director	Maryland Harford I	Edgewood	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show r must be rollfilled at	급	611 Lake Avenue			21040		USA	
	ns 22	Funeral	11 Marital Status 12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White	
30	be filed within 72 hours after death with the Marylan lat Hygiene.  and Hygiene.  do dher than "natural", or liems 23a or 28a-f show other than "natural", or liems 23a or 28a-f show event, Ira Medical Examinar must be notified at	by Fur	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No II Yes, Give  3 Nowed 4 Divorced Year or Dates:		1 ☐ Yes 2X No	Specify:	rican, etc.)	Specify: Whi	
9500-61212	2 hou		15. Decedent's Education	16a. Dece	edent's Usual Occupa	ation		6b. Kind of Business/Ir	ndustry
2	thin 7 e. an "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	1)			
7	filed wi Hygien ther th	ဥ	4	Home	emaker	18. Mother's Nam		own Home	
ם	d oth	Be	17. Father's Name (First, Middle, Last)			Christi			
<u> </u>		ပ္	Henry Lee Jackson	10h Mail	ing Address (Street			City or Town, State, Zi	p Code)
, Maryland	ad 2 in a lith ar lith ar 27 is rither		19a. Informant's Name/Relationship (Type, Print) Leslee Johnson / Daughter	114	Still Mea	adow Driv	e, Joppa	, Maryland	21085
altimore,	0 -		20a. Method of Disposition 1 StBurial 2 □ Cremation 3 □ Removal from State	<ul> <li>Place of Disp cemetery, cre</li> </ul>	osition (Name of ematory or other place	(e)		0c. Location - City or T	
Ĕ	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify) G		Forest V			wings Mills	s, Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	Í	2. Name and Addre	ineral Ho	me, P.A.	1- 10 01/	200
	20 F 4 0		23a. Part1. Enter the disease, or complications that caused the c	teath. Do not or	1317 Cokes	sbury Roa	or respiratory arre	don, MD 210	Approximate
			shock, or heart failure. List only one gause on each line.	/ / /	(c)	/	or respiratory arre	-	Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ceshula	n Mcc	· leng			s weeks
	Examiner		Oue to (or as a con	isequence of):	(1)	1 -100	cula 1	Dean	10-00
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	· · · · · ·	T (OVG)	ica (	1 isees	7000
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
ó	rtificate be executed ng physicien and as the burial-transit		resulting in death) Last Due to (or as a con	sequence of):					
68760,	ate be nysicii	Medical	d						
	ntifice ing pt	Med	IF FEMALE:						
Box	eath cer attendir I for use	lan/	23b. Was decedent pregnant  1 Live birth 2	Fetal death 3	☐Ectopic pregnancy	4		23d. Date of deli Month	Day Year
0	the a	Physiclan/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ordeath 5	Other (specify) _				
о. О.	that the		Part II/Other, significant conditions contributing to death but not	t resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	The law requires that the death cerate has been signed by the attendinges 2 should be detached for use	d by	Varlincon's Vislas	6			1 ☐ Ye	s 2 No 3 Pro	obably 4 Unknown
Vital Record	w require been si should i	Completed					24a. Was ar	24b. Were au	topsy findings available completion of cause of
Re	he lay	dmo					autops perform	ned? death?	22 No
ā	ifficati or, pe	Ö	25. Was case referred to medical			26. Pface of Dea	th (Check only on		
>	Physician: r this certifica ral director,	To B	examiner?	2 ER/Outpati	ent 3 DOA Ott	ner: 4 🗌 Nursing H	ome Sande	nce 6 🖸 Other (Spec	Daughter's
1 0	9 Phy ler thi		27. Manner of Death 28a. Date of Injury (Month, Day Yea	28b. Time Injury		ry at rk?	28d. Describe ho	w infury occurred	Residence
Ö	Attending or death.	atlo	1 Natural 5 Pending (Month, Day 1 et al., Da		M 1	Yes 2 □No			
Division	or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (St		street, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	iral Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	dical C	29a. Certifier (Check only one)  Certifying Physician: To the desit of my fund manner stated.	knowledge, de mination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complex	Med	29b. Signature and inte of counter		29c. Licens	se number	./٢	Date signed (Mont.	h, Day, Year)
	/		1/1/00/1	TO DA	up H	7907	z, 11	MARCH 2-	7 2006
	6		80. Name and address of person who completed cause of death	(Item 23a) (Typ	e, Print)	Comb.	Man	Edminul	MD
*	St	ate	31. Date filed (Month, Day, Year) 32. Adjistrar's S	Signature	A DE		14	/	- · · · · ·
	Regist		MAR 3 1 2006   December 1	St. A	Carles .				

		•	For State Registrar <b>Amend</b>	Item:		of Marylar L <b>PerVer</b>							Reg. No.	006	099	332		
	Physici	an	1. Decedent's Name (First,	Middle, Last)			Fra					2. Date of De Month	Day	2006	3. Time (			
*	/Medic	al	4a. Facility Name (If not ins	itution, give	street and n	umber)	IVA		, Town, or	Location	of Death	March	3,5 4c. 0	ounty of Death		<del>T</del> /		
	Examin	er	The Johns	,		spital		Ba	Itima	re	Cit	1			N/A			
	Funeral Director		5. Social Security Number 212-84-458	6. Se		7. Age (In yrs.	last birthday) 13 Yrs.	If Unde Months	or 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Aug	th y, Year) 8, 1962	Con	nplace (State untry) <b>Marylan</b>	_		
	pue *		Usual Residence of Deceder 10a. State 10b. C			10c. Ci	ty, Town or Lo	cation							10d. Inside (	City Limits		
	Maryli	ξ	Maryland		I/A				В	altimo	re				1 <b>□</b> ¥re	s 2∐No		
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. "Returer", or items 23e or 28e-f ehow marked other then "returer", or items 23e or 28e-f ehow matic event, the Madical Examiner must be notified at	I Director	10e. Street and Number 4821 Rogers A	venue			-	10f. Z	ip Code	21	215		10g. Citiz	en of What Co	untry? S.A.			
	death	Funeral	11. Marital Status		12. Was Dec	cedent Ever in U	J.S. 13. \	Vas Dec	edent of Hi	spanic Or	rigin? (Sp	pecify Yes or No Rican, etc.)	)- 1·	4. Race - Amer Black, White				
2	ours after rel', or its Examina	by	1 Wever Married 2 3 Widowed 4 Div			2 □ No iive			2 □ <b>X</b> 10	Specify				Specify:	Black			
5	72 h	etec	15. De (Specify only	cedent's Edu highest grad	cation <i>e completed</i>	)	16a. Deced	kind of w	ual Occupa ork done d use retired	luring mo:	st of work	king		d of Business/l				
4	within 72 ene. then 'nai	Completed	Elementary/Secondary (	)-12)	College	(1-4or 5+)	ille. L	DO NOT	Accou		Agent		lr	nternal Rev	venue Se	ervice		
7	be filed ital Hygie od other event,		12 17. Father's Name (First, N	iddle, Last)			1			18. Moth	er's Nam	ne (First, Middle	, Maiden S	Sumame)				
Maryianu zizio-0050	should be find Mental I marked of umatic eve	To Be			a Frasie	r							ueen		r- 0- d-1			
	alth a		19a. Informant's Name/Re Queen A. Fras				1	•				nal Route Numb Baltimore,			up Coae)			
ש	Pages 1 ar		20a. Method of Disposition 1 ☐ Surial 2 ☐ Crem 4 ☐ Donation 5 ☐ Of				Place of Dispo cemetery, cren W	natory or	ame of other place Cemet	1		Date 03/31/06		ation - City or Baltim	Town, State ore, Md.			
Dall	permit. Pages Department of Important; If it eny injury or o		21. Signature of Funeral S	ervice Licens	. 1	Jacke	A R 22	2. Name	Estep E	Brothe	rs Fun	eral Service	P. A.	17				
	Thusinian		23a. Part 1. Enter the diseashock, or heart failure Immediate Cause (Final	ise, or comple. List only o	1	caused the dea each line. cterial	U	2	ode of dying						Approxim Interval B Onset and	etween d Death		
	Physician /Medical Examiner		disease or condition resulting in death)	-	Due to	(or as a conse	quence of):		12						12 h			
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,0070	ficate be executed physicien and is the burial-transit	dicai	d															
DIVISION OF VITAL RECORDS, P.O. BOX of	Physician: The law requires that the death certificate these been signed by the attending it this certificate hes been signed by the attending raid director, page 2 should be deteched for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregning the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown	int	1 🗀 Live	utcome of pregn birth 2 Fet gnant at time of nown	al death 3□	Ectopic Other (	pregnancy specify)				2	3d. Date of del Month	ivery Day	Year		
Ţ.	s that th	by Ph	Part II. Other significant c	onditions co	ntributin <b>g</b> to	death but not re	sulting in the u	ndertying	cause give	en in Part	l.	23e. Did	tobacco us	se contribute to	the cause o	of death?		
2	en sig	ed t										10	Yes 27	No 3□Pr	obably 4 [	Unknown		
Jac	S C1	Completed								-		24a. Was auto perf 1 ☐ Yes		death?	utopsy finding completion o	s available cause of		
<u>0</u>	ilcian: Th certificate rector, pag	BeC	25. Was case referred to r examiner?								ce of Dea	ith (Check only	one)					
N 10 L	ding Physic n. After this ce funeral dire	2	1 ☐ Yes 2 No 27. Manner of Death	Pending	Hospital: 1)2 28a. Dat (Mo	Inpatient 2 [ e of Injury onth, Day Year)	28b. Time o		28c. Injun	4 🗆 🗅	lursing H	ome 5 ☐ Res 28d. Describe			cify)			
INISIO	or Attendi ter death. Irector: A n by the fu	Certification:	2 Accident	nvestigation Could not be determined	28e. Pla	ce of Injury - At I	nome, farm, str ify)	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office 28						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ב	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 M	ertifying Phy	iner: On the	he best of my kn basis of examin	owledge, deat ation and/or in	h occurre	ed at the tin	ne, date a	and place	, and due to the	cause(s) , date and	and manner as place, and due	s stated.	e(s)		
	thin 2 the I the I mplet	Medical	one) 29b. Signature and title of			inner stated.			9c. Licens					signed (Mont				
	7 × 2 8		▶ Maris		1,100	Medica	Odocto		RE				mar		2006	5		
•	\0		30. Name and address of						, -, -		-		1 . (4/1	0123	1			
	W		MarissaBlu		John	stopkin	s Hospit		00 Nor	+h w	olfe S	Street Bo	altimer	e, Mary	land 2	J1287		
	Sta Regist	ate	31. Date filed (Month, Day	Year)	32	Registrar's Sign	nature					•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 30, 10:55 A M March Vernon E. Geis, Sr. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11 Holmes Avenue Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 214-01-9141 July 26, Director 88 1917 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehow tre Medical Examinar must be notified at Maryland Baltimore Catonsville 1 ☐ Yes 21 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 11 Holmes Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ti⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1945–46 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Ship Yard permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other eny light of other treumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer C. Geis, Sr. Mabel A. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally V. Wescoat - daughter 894 Gordon Drive, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 4/3/2006 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 months Cirrhosis Liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete has been sig Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 XNo After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No investigation М 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal

within 24 hours after deat To the Funerel Director: 0+1

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only

29b. Signature and title

31. Date filed (Month, Day, Year) MAR 3 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

certifier

Seenivasan, MD



29c. License number

D17743

29d. Date signed (Month, Day, Year)

March 31, 2006

		1 - For State of Maryland / Dep Registrar Ce	partment of Health and ertificate of Death		giene 1006	09934
Physici /Medio		1. Decedent's Name (First, Middle, Last)  Reay Elizabeth Groner		2. Date of Dea Month March 2	Day Year	3. Time of Death 10:35AM M
Examir		4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Deal Timonium		4c. County of Deal Baltimore	9
Funeral Director		5. Social Security Number 215-42-8883  Usual Residence of Decedent	// If Under 1 Year If Under 24 Hrs Months Days Hours Min		7,1911 Per	hplace (State or Foreign MSylvania
Maryland a-fehow	ctor	MD Baltimore Baltimo				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
oth with the 23a or 28	al Dire	10e. Street and Number 1205 Linkside Drive	10f. Zip Code 21234		10g. Cilizen of What Co	ountry?
ING 21215-0035  be filed within 72 hours after deeth with the Maryland hat Hygiene. d other then "natural", or items 23s or 28s-f show event, the Medical Examber could be putilised at	Completed by Funeral Director	11. Marital Slatus  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 () No Specify:	Specify Yes or No- rto Rican, etc.)		
Z1Z15-0036 d within 72 hours at glene. er then "natural; or the Madical Exam.	ompleted	(Specify only highest grade completed) (Giv	edent's Usual Occupation le kind of work done during most of wo DO NOT use retired) DMEMAKEY	prking	16b. Kind of Business Own Home	Industry
Maryland	To Be C	17. Father's Name (First, Middle, Last) Clarence R. Allender		E. Bowen		
end 2 sho eelth and m 27 le ma her treum		Mrs. Mary L. Paxton-Daughter 120!	ling Address (Street and Number or R 5 Linkside Drive E	Baltimore	, Maryland	21234
Baltimore, Marylar permit. Pages 1 end 2 should by Department of Heelth and Menta Important: If them 27 te marked any injury or other treumatic e		4 Donation 5 Other (Specify)	d Memorial 3/30		20c. Location - City or Baltimore, J. Ruck, I	Maryland
Departiment in portion		Heather Carx	22. Name and Address of Facility 5305 Harford Road	Baltimor	e, Marylan	d 21214
S/60, ale be executed /Medical physician and the buriar-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	delampens	4	est,	Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/ The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
ecords, P. law requires that as been signed b,	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute lo	the cause of death?
	Completed			24a. Was a autop: perfor 1 \( \text{Yes} \)	sy prior to	itopsy findings available completion of cause of
VITA siciens certific irector,	To Be	25. Was case referred to medicat examiner?  1 Yes 2 16 Hospital: 1 Inpatient 2 EP/Outpatient	Other	ath (Check only or	ence 6 Other (Spe	0.6.1
ing Ph ling Ph Aftar th uneral		27. Manner of Death 1 Maturat 5 Pending (Month, Day Year) 2 Accident Investigation			ow injury occurred	шу
DIVISION itel or Attanding us attar death. rai Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home, tarm, s building, etc. (Specify)		City or Tow		
To the Hospitel or within 24 hours at To the Funarai D	ledical	29a. Certifier  (Check ow)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occi	urred at the time, d	late and place, and due	to the cause(s)
To with	Σ	30. Name and address of person, who completed cause of death (Item 23a) (Type	29c. License number		3/28/00	h, Day, Year)
57		1000	Printsler Brive	Sull Za	Tousan	MDZIZOY
Sta Registr	ar	31. Date/filled (Month, Day/Year) 32. Registrar's Signature  MAR 3 1 2006	berli)			
DHMH 17 Rev 1/2	001		•			

ORIGINAL

Certificate of Death

For State Registrar

		Decedent's Name (First, Middle, Last)				2. Date of Death Month		Vess	3. Time of Death
Physici /Medic		Doris M. Herman		March	30 30	2006	12:10 a <sup>M</sup>		
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death			y of Death	
		Gilchrist Center for Hospice Care		Towson	If Hades Od Hrs	1.5.		timor	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC 6 1	Year)	9. Birthp Coun	lace (State or Foreign try) MD
Director		218-03-6824 90 Usual Residence of Decedent				DEC 0 I	913		VIID .
yland		10a. State 10b. County 10c. City, To	wn or La	ocation				1	Od. Inside City Limits
e Ma	ç	MD Baltimore Baltin	nore						1 ☐ Yes 2 🖺 No
vith th	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of		try?
s 23s	erai	919 Arran Road  11 Marital Status 12. Was Decedent Ever in U.S.	12.1		239 Hispanic Origin? (Sp	positiv Voc or No	US	A ce - Americ	an Indian
tter de	Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Yes  2 ☑ No	13.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		ick, White,	
al', ol	þ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	fy: wh:	ite
72 hc	etec	15. Decedent's Education 16. (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of work	ring	16b. Kind of E	Business/Inc	lustry
within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired	•		Co	<i>:</i>	
Hygie Hygie ther i	ပို	17. Father's Name (First, Middle, Last)	тете	phone Ope	18. Mother's Nam	e (First, Middle, N			cations
d be antal	To Be	James Buchall			Marie	Meusha		,	
shound Mark	-	19a. Informant's Name/Relationship (Type, Print) in 1aw 19			and Number or Rui	al Route Number,	City or Town	, State, Zip	Code)
and 2 aith a 27 is		Norma J. Herman - Daughter	919	Arran Roa	ad, Balti	more, MD	2123	9	
ot He ot He fiten		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State	of Dispo ery, crer	osition (Name of matory or other place		Date 2	20c. Location	- City or To	wn, State
Pag tment tant: jury c		4 □Donation 5 □Other (Specify) Chesa	-		ory 3/31	-	Beltsv		
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: if item 27 is marked other then "natural", or items 23s or 28e-f show eny injury or other traumatic event, the Medical Examinal must be notified at page.		21. Signature of Funeral Service Licensee  MO0986	Č	AFA, Ster	phen D. L n Pasture	ohrmann,	PA	. MD	04.006
10100		23a. Part1. Enter the disease, or complications that caused the death. Do						n, MD	21286 Approximate
		shock, or heart failure. List only one cause on each line.				or roopilatory arre	001,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a.   Ty treme	de	bility					years
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Extreme  Due to (or as a consequence of the conditions)  Sequentially list conditions	le	Stroke	5				years
	Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying							<i>-</i>
ocuted and transi	Examiner	Cause (Disease or injury that initiated events c.							
sath certificate be executed attending physician and tor use as the burial-transit		resulting in death) Last Due to (or as a consequence	e of):						
physicate s the l	an/Medical	d							
certif nding Jse a:	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d, Da	ate of delive	nv
death e atte	icia	in the past 12 months?  1 Ves 2 DNn  4 Pregnant at time of death		Ectopic pregnancy Other (specify)	y 		М	onth	Day Year
To the Hospitel or Attending Physicien: The law requires that the de within 24 hours atter death. To the Funerel Director: After this certificate has been signed by the a completely filled in by the funeral director, paga 2 should be detached to	Physici	9 □ Unknown 9□ Unknown							
es thatigued be de	ρ	Part II. Other significant conditions contributing to death but not resulting I m m o 5 % Lify Secondary To De							e cause of death?
een s	Completed		90	rici of ino	Jour	1  Ye	es 2 ZNo	3 ∐ Prob	ably 4 □Unknown
e faw has b	nple	disense of the spine				24a. Was ar autops perform	V	Were autoprior to condeath?	osy findings available apletion of cause of
n: The		V				1 ☐ Yes 2	2/2No		2 No
sicier certit irecto	o Be	25. Was case referred to medical examiner?  1   Yes 2   No	)	nt 3 DOA Oth	000	h (Check only on			11 - 131
g Phy er this eral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b.	. Time of			ome 5 Reside 28d. Describe ho	-		Hispice
ath. rr: Aft	atio	2 Accident investigation	Injury		Yes 2 □No				
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	reet, factory, office		28f. Location (Str. City or Town	reet and Num n, State)	ber or Rura	l Route Number,
urs att									
Hosg 24 ho Fundately f	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge of the desired physician: To the basis of examination a and manner stated.	ge, death ind/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and mate and place.	nanner as st , and due to	ated. the cause(s)
o the	Me	29b. Signature and title of certifier		29c. Licens	se number	25	9d. Date signe	ed (Month, i	Day, Year)
F > F 0		M. Hather Iller.	m	0 00	25205	-	MA	rch 3	0,2006
01		30. Name and address of person who come of death in em 23a	) (Type,	Print)		4.5			
\		W A. Riley GIBMC 67011	Y. C	hmles	St. Ba	170 N	12 2	120	<u> </u>
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature		200					
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11 11GA 1/C									

				aryland / l .,G853,	Department of I 03/31/06dhb Certificate of	lealth and N Death			09936
Physic	ian	Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
/Med Exami	ical	4a. Facility Name (If not institution	give street and number)			7 BERG r Location of Death		4c. County of Dea	
Funeral Director		JOHNS HOPKI 5. Social Security Number 216-58-2197	OS BAYVI	EVV ge (In yrs. last bi 45	inthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12/2	9 Bir	thplace (State or Foreign buntry)
yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Location				10d. Inside City Limits
Ba-fah	Director	MD Balti	more	Dunda					1 ☐ Yes 2 No
h with th	ai Dire	10e. Street and Number 3125 Walford Di	rive Apt. A		10f. Zip Code 21222			10g. Citizen of What Co United Sta	
be filed within 72 hours after deeth with the Maryland stat Hygiene.  Id other than "natural", or items 23a or 28a-f ahow event. The Medical Expiration into the incitied at	by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? and I Tyes 2 Strain Yes, Give Year or Dates:	?	13. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
within 72 hc ene. than "natur he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		54)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired  Lerk	pation during most of work d)	king	16b. Kind of Business Service S	
ild be filed within tental Hygiene. 'ked other than '	To Be Cor	12 17. Father's Name (First, Middle, Robert Franklin		-	Telk		ne (First, Middle, McKinney	Maiden Sumame)	
nd 2 shou lith and M 27 is mai	F	19a. Informant's Name/Relationsl Robert Herzberg			b. Mailing Address (Street 7807 Deboy A				Zip Code)
00		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 4 ☐ Donation 5 ☐ Other (S)		cemete	of Disposition (Name of ary, crematory or other pla apeake Crema		Mar 26 2006	20c. Location - City or Beltsville	
permit. Pag Depertment Importent: I any Injury o		21. Signature of Funeral Service	icensee M	01443	22 Name and Addre Cremation 8717 Green				aryland 2128
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Acu Due to (or as Morbio	ine.	ENAL FA		or respiratory ari	rest,	Approximate Interval Between Onset and Death
ificate be executed g physicien and as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	of):				
iaw requires thet the death certifi as been signed by the attending. 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal deat	h 3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
w requires thet been signed b should be deta	ğ	Part II. Other significant condition	ns contributing to death t	out not resulting	in the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t es 2 No 3 □ P	o the cause of death? robably 4 □Unknowr
The ete ha	Completed						24a. Was a autop perfor 1 \( \text{Yes} \)	sy prior to	utopsy findings available completion of cause of s 2 No
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Dea			
Phys this aldir	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju		dipatient 30 00A	4 🗆 Nuising n		ence 6 Other (Spe	ecify)
anding ath. or: After he fune	ation	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, Da jation	ay Year)	Injury Wo	rk?  Yes 2□No	Zou. Describe in	Ow injury occurred	
Hospital or Attending 14 hours after death. Funerel Director: After tely filled in by the tune	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined   286. Place of in	ijury - At home, f tc. <i>(Specify)</i>	arm, street, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	lural Route Number,
To the Hospital or Att. within 24 hours after de To the Funerel Direct completely filled in by the Completely fill	Medical (	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner st	of examination a	ge, death occurred at the ti nd/or investigation, in my o	me, date and place opinion, death occur	, and due to the or rred at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
Withir To the Comp	ž	29b. Signature and title of certifier	•		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
X		Ontoing to 30. Name and address of person	M. Valent			ES-00	0	03/24	1106
V\	tate		M. VALENTI	MD trar's Signature	4940 EAS	TERN A	WE BA	LTIMORE	MD 2122
Regis		MAR 3 0 2	006 Kenny	M. A	parle				
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ORIGINAL

			1 - For State Registrar	State of Maryland		of Health and of Death		iene 0 0 6	09937
	Physici		Decedent's Name (First, Middle, Last)	- Hou	ah		2. Date of Death Month MARCH	Day Yeer	3. Time of Death
).	/Medic Examin		4a. Facility Name (If not institution, give			Town, or Location of Dea		4c. County of Deal	b / / / / / / / / / / / / / / / / / / /
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, las	t birthday) If Under			9. Birt	hplace (State or Foreign
	Director		212-44-2328 10 Usual Residence of Decedent	M 2015	3 Yrs. Months	Days Hours Min	JUNE 25	Year) Co	ARYLAND
3	how how		10a. State 10b. County	10c. City, 7	Town or Location	)			10d. Inside City Limits
4	289-1 s	Director	MARIJAND N /	R	10f. Zip	ALTIMO		TY	1 AYes 2 □ No
<u>.</u>	23a or		4/11 HARR	15 AVENL	1E	212	06	og. Citi≱en of What Co	A .
	Items Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Deced	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
5-0036	lal Hygiene incoming a new years with the maryland it Hygiene.  d other then "natural", or items 23a or 28e-f show event, if a Medical Examiner mast be inclified at	þ	3 NWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	因No Specify:		Specify:	LACK
-512	n "natu Medica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Usual (Give kind of work life. DO NOT use	l Occupation k done during most of wo e retired)	rking	6b. Kind of Business/	Industry
N 3	ntal Hygiene. ed other then c event, tre M		Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER			tomE
<b>S</b> 3		To Be	17. Father's Name (First, Middle, Last)	BI	SHOP	11.0	me (First, Middle, N	faiden Sumame)	154A
lary	and Men ls marke eumatic	-	19a. Informant's Name/Relationship (Ty)	10-	19b. Mailing Address	(Street and Number or R		City or Town, State, 2	Zip Code)
			TAMMY MORGAN  20a. Method of Disposition	20b. Plac	e of Disposition (Nam	RRIS AV	E BAL	70. HA.	2/206 Town, State
	0		9 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		etery, crematory or oth RISON F	ner place) REST 04-		Dwings.	MILIS MD
Balt	Department Importent: Il any injury o		21. Signature of Funeral Service License			Address of Facility		R. FUNE	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the deeth.	Do not enter the mode	of dying, such as cardia	or respiratory arra	13/4/10, st,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	CVA					Onset and Death
	/Medical xaminer			Due to (or as a consequen	nce of):				
/ 7	ls it	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):				
, j	hysician and the burial-transit	Examine	that initiated events cresulting in death) Last	Due to (or as a consequen	nce of):				
death cedificate be execut	physician s the buria	dicai							
HOX OF	attending p	an/Me	230. Was decedent program	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetel de		onenou.		23d. Date of deli	very
5	2 5 9	Physician/M	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4 Pregnant at time of death				Month	Day Year
Ords, P.	signed by the a	by Ph	Part II. Other significant conditions con	tributing to death but not resultir	ng in the underlying ca	use given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
COLD	hou				-		-	2 No 3 Pro	
ב ב <u>ק</u>	2 28	Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
	ector, p	Be	25. Was case referred to medical examiner?	itali		-	1 ☐ Yes 124 ath Check only one		22No
O Phys	eral dir	n: 10	27. Manner of Death	ospital: 1 Inpatient PER  28a. Date of Injury (Month, Day Year) 28		C. Injury at Work?	lome 5 Resider	nce 6 Other (Spec	ify)
UIVISION Pr Attending	leath. Ior: Aft the fun	catio	✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 Yes 2 No			
	after of Direct	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
DIVISION OF VICE	within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edicai C	(Check only 2   Medical Examin	Ician: To the best of my knowle er: On the basis of examination	dge, death occurred at and/or investigation, i	t the time, date and place n my opinion, death occu	, and due to the cau	use(s) and manner as	stated.
Tothe	To the	Med	one) 29b. Signature and title of certifier	and manner stated.		License number		d. Date signed (Month	
·	n		> Mm, MD		[	15772	7	3/30/0	6
	7		30. Name and address of person who cor	mpleted cause of death (Item 23	a) (Type, Print)  2 Maw	het 1/20	e Au	Arch.	MD 21222
	Stat Registra		31. Date filed (Month, Day, Year) MAR 3 1 200	32 Registrar's Signature					

			1 - State Registrar Amend Item	State of Marylan				giene	06	19938
	Physici	an	1. Decedent's Name (First, Middle, Las.  FLORENCE HAR	7)	8000 0,02		2. Date of De Month MARCH	ath _Day	2006	3. Time of Death 5:30P M
	/Medic Examin	- 1	4a. Facility Name (If not institution, give		4b. C	ily, Town, or Location of De			unty of Death	J. 30E
	LXaiiiii	G1		LD COURT		RANDALLSTOV		В	ALTIMO	ORE.
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		nder 1 Year   If Under 24 H	rs. 8. Date of Birt	h		place (State or Foreign ntry)
v.	Director		215-12-8343 Usual Residence of Decedent	□M 2MF 93	Yrs.	ns cays mours with	08/23			CAROLINA
	a-f ehow	ctor	10a, State 10b. County	10c. Cit	Town or Location	more				10d. Inside City Limits
	th with the 23a or 28 18t be no	Funeral Director	10e. Street and Number	nwood	Pd 101.	Zip Code 2/2/3		10g. Citizen	of What Cou	A.
036	be filed within 72 hours after death with the Maryland tal hygiene. Id other then "natural", or teme 23a or 28a-f ehow event, the Medical Examinar must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates:	If Yes,	specify Cuban Mexican, Purs 2 No Specify:	(Specify Yes or No erto Rican, etc.)		Race - Ameri Black, White, ecify:	
21215-0036	within 72 ho lene. then "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's t (Give kind of liter DO NO	Jsual Occupation f work done during-most of w J use retired	rogking	16b. Kind	of Business/Ir	1 01
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)	/		18. Mother's N	lame (First, Middle,	Maiden Su	mame) Dei	-
lan	s 1 and 2 should I Health and Mer Item 27 is marks other traumatic	80 8	19 /ormant's Name/Relationship (7	ype, Print)	19b. Mailing Addr	ress (Stree) and Number or	Rural Route Numbe	er, City or To	State, Zi	o Code)
-	1 and Health em 27	٠,	Cille Kob.	2500	9003	Sogla	oud y	60 1	Dest	MD2125
Baltimore	permit. Pages 1 Department of H importent: if ite eny injury or ott		a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition ( pametery, crematory		01/2006	20c. Locat	ion · City or T	MD,
Balt	permit. Departimport eny inj once.		21. Signature of Funeral Service Licens	See A. Nown	22. Name	1		FUNEF AVE.,		ME 21207 IMORE, MD
	Sel		23a. Part1 ter the disease, or composition of the c	lications that caused the dealers one cause on each line.	h. Do not enter the r	mode of dying, such as card	iac or respiratory a	rest,		Approximate Interval Between
	Physician /Medical	n i	Immediate Cause (Final disease or condition resulting in death)	a CORUNA		1224 D15	EAS E			Onset and Death
	Examiner			Due to (or as a conseq	(uence of):					
7	P #	Iner	Sequentially list conditions, harry, roading to inmediate cause. Enter Underlying	b. Eue to (or as a consec	imence of):					
V	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):					
8760	b ys	cal		d					-	
O. Box 6	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 Ectopi	ic pregnancy (specify)		23d	Date of deliv	rery Day Year
s, P.O.	es that the de igned by the a be detached t	by Ph	Part II. Other significant conditions or		sulting in the underlying	ng cause given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ords	w require been sig should b		HYPERTEN	1500	· · · · · · · · · · · · · · · · · · ·		- 101	res 2□N	lo 3∏Pro	bably 4 Donknown
Vital Records,	The law rate has be page 2 sh	Completed					24a. Was auto perfo 1 Tyes	rmed?	death?	opsy findings available ompletion of cause of
/ita	Physician: this certifica ral director, p	Be (	25. Was case referred to medical examiner?				eath Check only			
<del>o</del>	Physis this c	၉	1 ☐ Yes 2 12 No	Hospital: 1 ☐ Inpatient 2 ☐		DOA Other: 4 Divursing				fy)
ion	<b>5</b> 6	atlon:	27. Manner of Death  1 ☑Natural 5 ☑ Pending  2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injury o	ccurred	
Division	tel or Attendii s after death. el Director: Al ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Location ( City or To		lumber or Rur	al Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	dical	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and pla tion, in my opinion, death oc	ice, and due to the courred at the time,	cause(s) an date and pla	d manner as a	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License number			igned (Month	
):			but m.	D		D0059107		03-	-30-2	_006
	3		30. Name and address of person who c			AVE NUS	BALTIMU!	25	MD 2	1215
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 200	6 2. Registrar's Sign	ature	)				

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Edward Hock, Sr. March 29, 2006 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1307 W. Jarrettsville Road Forest Hill Harford If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Year)

Jan. 10, 1 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 2□ F 215-30-0543 74 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location "natural", or items 23a or 28a-f show older Exercicer must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1307 W. Jarrettsville Road 21050 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Parts Manager 12th Grade Trucking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Germanus Sebastian Hock Helena Kleinhen 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other treum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shirley E. Hock 1307 W. Jarrettsville Rd., Forest Hill, MD (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 4/1/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Busin a Wille 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea Immediate Cause (Final **Physician** mon 15 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine rsician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 Division of Vital To the Hospitel or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 2 Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide hours after filled in Fo true within 24 hour. •he Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hon EE KAlu m-10

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Mont)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Parkville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, October)

Reg. No.

29,

<sup>Year)</sup> 1921

2006

4c. County of Death

Baltimore Co.

United States

14. Race - American Indian,

White

Black, White, etc.

Specify:

Own Home

23d. Date of delivery

1 TYes

Day

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 1 No

Road

Approximate Interval Betw Onset and Death

21214

Maryland

3. Time of Death

07:50 a.<sup>M</sup>

2. Date of Death

Month

March

**Physician** /Medical Examiner

**Funeral** 

Director

Decedent's Name (First, Middle, Last)

Mary

4a. Facility Name (If not institution, give street and number)

Oak Crest Care Center

6. Sex

Herman

1 □ M 2 💢 F

7. Age (In yrs. last birthday)

Yrs.

84

Helen

5. Social Security Number

216-24-3472

Usual Residence of Decedent

'natural', or Items 23a or 28a-f show

State Registrar DHMH 17 Rev 1/2001 monias

31. Date filed (Month, Day, Year)

8800

MAR 3 1 2006

walther

32. Progistrar's Signature

Boo la vouro

Parkville MD

			For State Registrar	State of Marylan	-	ent of Health and ate of Death		iene og. No.	09941
	Physici	an	1. Decedent's Name (First, Middle, L	·			2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic	al	JOHN	HERP		7	MARCH	24 200	
1	Examir	er	4a. Facility Name (If not institution, g HARBOR HO	SPITAL	46. 0	City, Town, or Location of Dea	RF	4c. County of Dea	th
	Funeral			Sex 7. Age (In yrs.		nder 1 Year II Under 24 Hr		9. Bir	hplace (State or Foreign
	Director		214-12-2258	12M 2 F	Yrs. Mont	hs Days Hours Mir	9-10-		RYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location	•			10d. Inside City Limits
	Many i-f ah	ţō	MD ANGLE A	DINNEL G	LEN B	URNIE			1 ☐ Yes 2 ☑ No
	th the	Funeral Director	10e. Street and Number			Zip Code	10	Og. Citizen of What Co	ountry?
	ath w	ral	1066 7th 5			人1060		U5,	4
	item item	une	11. Maritat Status  1 ☐ Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	.S. 13. Was De	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit	encan Indian, e, etc.
98	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:		Specify:	MITE
215-0036	filed within 72 hours after death with the Maryland Hygiane. yther than "natural", or itema 23a or 28a-f ahow ant, the Mudical Examinar must be notified at	Completed	15. Decedent's (Specify only highest g		16a. Decedent's U	work done during most of we		16b. Kind of Business	Industry
12	within ane. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired)		"hEMICA	1 Co.
2	filed with Hygiane other tha	Be C	17. Father's Name (First, Middle, Las	51)		18. Mother's Na	ame (First, Middle, A	faiden Surname)	
/lan	should be nd Mental marked matic av	To B	Charles	HERPEL		SELMA	EVERSI	MEIER	
Maryland	C/ a = =		19a. Informant's Name/Relationship		19b. Mailing Add	ess (Street and Number or F	. 0		Zip Code)
	1 and Health am 27 ther tr		20a. Method of Disposition	VEL WIFE	Place of Disposition (	Name of	Date 2	20c. location - City or	Town State
פֿר	Pages nent of I int: if Its iry or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	cemetery, crematory	or other place)	27-06-1	LAR.	in MA
Baltimore,	permit. F Departmo Importar any injur		21. Signature of Emplat Service Lic			and Address of Facility		SCHOURA	ile, My.
m —	Depa Impo Impo any ir		X.N.V.	white the		au therry Family Funeral 2601 Mountain Rea	d - Pacadona M	D 21122	
				y one cause on a status.	h. Do not enter the r	node of dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical	9 14	Immediate Cause (Final disease or condition resulting in death)	a ISCHEMI		DIOMYOPI	ATHY		9 DAYS
	Examiner			Due to (or as a conseq ATRIAL F	Uence of): IBRILL	ATION			In DAVS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq		111010			10 0113
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.	ALEMIA				10 DAYS
8760,	icate be executed physicien and s the burial-transit		vestiling in death, cast	Due to (or as a consequent	uence of):				
687	ficate p phys	edicai		d					
Вох	leath certific attending p	M/N	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome of pregna		c pregnancy		23d. Date of de	ivery
m C	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of di				Month	Day Year
P.O.	res that the de signed by the a be detached f	, Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the underlyin	ng cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records,	quires n sign lid be	d by					1 ☐ Ye	s 2 No 3 1	obably 4 Unknown
<u>Ö</u>	law require as been si 2 should b	piete					24a. Was ar	24b. Were as	utopsy findings available
ř	The ete h	Completed					autopsy perform	ned? death?	completion of cause of
VIta	Attending Physician: ir death. ector: After this certific by the funeral director.	Be	25. Was case referred to medicat examiner?	Hospital:		0.4	ath (Check only one		
0	Phys r this ral dir	5 T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Minpatient 2	ER/Outpatient 3 28b. Time of		Home 5 Reside	nce 6 Other (Spe	cify)
o	nding lath. r: After e funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
≥IS	I or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not determine		ome, farm, street, fac	story, office	28f. Location (Str City or Town	reet and Number or R	ural Route Number,
	ors aft								
	To the Hospitel or At within 24 hours after of to the Funeral Direction by completely filled in by	edicai	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occur ition and/or investigat	red at the time, date and plac tion, in my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	within To the Somple	Me	29b. Signature and title of certifier	0		29c. License number		d. Date signed (Mont	h, Day, Year)
}	Y		AEm	L- MD		OOORE:	SI	IARCH 24	1,2006
4	6		30. Name and address of person who			NOVER STOF	CT DAIT	MOOT MA	DV. A.A. DIDD
	Sta	te	ALI EMAMHOS  31. Date filed (Month, Day, Year)	32. Régistrar's Signa	iture.	NOVER STRE	EI BHLI	IMUKE MH	MILMN V dldd
	Registr	ar	31. Date filed (Month, Day, Year) MAR 3 1	2006 Alexans.	15 page 200				

			State of Maryland /		Health and M	lental Hygie	ene	9942
	Physici		1. Decedent's Name (Frst, Middle, Last)	- Certificate Of	Deam	2. Date of Death Month	Day Year 3.1	Time of Death
j	/Medic Examin		4a. Facility Name (If no institution, give street and number)  Bon Secours Hospital	4b. City, Town,	or Location of Death Balti	more	4c. County of Death	•
	Funeral Director		5. Social Security Number 219-38-5167  Usual Residence of Decedent	birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, ) Feb 26,	(ear) 9. Birthplace (Country) 1940 So.Ca	State or Foreign Irolina
	Maryland a-f ehow	tor		own or Location	Baltimore			side City Limits ☐Yes 2 ☐ No
	th with the 23a or 28a	al Director	10e. Street and Number 220 Mt. Holly Street	10f. Zip Code	21229	100	U.S.A.	
980	hours after death with the Maryland lural; or Iteme 23a or 28a-f ehow at Extruitier court be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Inc Black, White, etc. Specify: Blac	
Maryland 21215-0036	within 72 ene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)  12	6a. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir Track &	upation e during most of work red) & Road Worke	ing	b. Kind of Business/Industry Railroad	
yland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)  Ernest Holmes				ces Julius	
	s 1 and 2 sho if Health and Item 27 is m other traum		Frances Marshall Mother	220 Mt. Holly	Street Baltime	ore, Maryland		
Baltimore,	it. Pages 1 rtment of H rtent: if its njury or ot		20a. Method of Disposition  1 □ Burial 2 □ X remation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligensee	of Disposition (Name of atery, crematory or other place)  Metro Cremator  22. Name and Add	ry, Inc	04/03/06	Catonsville, Mar	
Ba	Derm Depa impo eny i		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	Estep 1300	Brothers Fune Eutaw Place B	altimore, Md	2121/	roximate
68760,	Medical Examiner bhysician and bhysician and the purial-transit	dicai Examiner	shock, or heart failure. List only one cause on each line.  Immèdiate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions of the c	ce of): Ce of)	lmina i hea alilis	il in	factions disease	val Batween et and Death
P.O. Box (	The law requires that the death certificate are has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □Ectopic pregnan			23d. Date of delivery Month Day	Year
	quires that in signed b uld be deta	þ	Part II. Other significant conditions contributing to death buffnot resulting	g in the underlying cause g	given in Part I		cco use contribute to the cau	use of death?
Vital Records,		Completed	Japanotomy Rysis	oroin a	ddict	24a. Was an autopsy performe	24b. Were autopsy fing prior to complete death?  No 1 ☐ Yes 2 ☐ 1	ion of cause of
Division of Vita	Attending Physician: r death. ector: After this certific by the funeral director,	ation: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	b. Time of Injury 28c. In	Other: 4 Nursing Ho	h (Check only one, ome 5 Residen 28d. Describe how	ce 6 ☐Other (Specify)	
DIVIS	i Digita	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	е	28f. Location (Stre City or Town,	et and Number or Rural Rou State)	te Number,
	the Hospitel hin 24 hours a the Funerat I npietely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled to the basis of examination and manner stated.	and/or investigation, in my	y opinion, death occur	red at the time, dat	e and place, and due to the d	Val
)	5 2 kit 6 2 kit 7 €		29b. Signature and title of Artiflet	D C	nse number 20267	20	3 27 0 i 3 Balture 8	5
	V		30. Name and address of berson who completed cause of death (Item 23:		Midy	19404	. Balture S	12/223
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,			

DHMH 17 Rev 1/2001

ORIGINAL

Time	of Ver	Al	3/18/06 Please T	ype or Print in	Black Indel	ible Ink. Ensure	All Copies Aı	e Legible.	
_			1 - For State Registrar	State of Maryla	ind / Departn	nent of Health and cate of Death		ne 0 0 6	09943
	Physici /Medic		1. Decedent's Name (First Middle, Last)	, Krais	e		2. Date of Death Month MARCH	Day Year 2000	
3	Examir	ner		sing Cente	2R /	City, Town, or Location of Dea	R	8 ACTIM	
-	Funeral Director		5. Social Security Number  316-01-1134  Usual Residence of Decedent	7. Age (In yrs		Under 1 Year If Under 24 Hr. inths Days Hours Mir			inthplace (State or Foreign Country) ALYLAUL
19/2	ith the Maryland or 28a-f ehow	tor	10a. State 10b. County	10c. C	City, Town or Locatio	n TIMORE			10d. Inside City Limits 1 ☐ Yes 2 ☑4√0
13/1		al Director	10e. Street and Number 5/6/6 Bright	Loaf Court	- 10	21237.	10g.	Citizen of What C	
5.5% 008; -0036	urs after death v el', or Iteme 23a zan deat must	by Funeral		12. Was Decedent Ever in Amed Forces?  1  Yes 2 D No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Origin? (i, specify Cuban, Mexican, Pue Yes 2 PNo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
21215-0	within 72 hours after ene. then "naturel", or Ite he Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kind	usual Occupation of work done during most of wo OT use retired)	orking	Stevi	0, 1.
$\mathcal{E}_{j}$ $(A/\nu_{i})$ Maryland 2	d 2 should be filed within 72 h th and Mental Hygiene. 7 is marked other than "natu traumatic event, the Medical	To Be Co	17. Father's Name (First, Middle, Last)	rause	Caro		ime (First, Middle, Maid i Zabeth		ther
GI)	and 2 sho ealth and n 27 Is m		19a. Informant's Name Relationship (Ty,	SR-grandso	n 2400	dress (Street and Number or F	Sol Air M	ry or Town, State,	Zip Code)
KRAUSE Baltimore, I	permit. Pages 1 am Depertment of Heali mportant: If Item 2 my Injury or other 2008.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposition cometery, cremator	y or other place) Mem. Val K 4/	1/06 B	Location - City of	r Town, State
A Ball	Depermine Depermine Impour Ir any Ir any Ir once.		21. Signature of Funeral Service License	Sayetty	[yan]	ne and Address of Facility B S Functor Char	altimore, sel, 0800 H	anford k	239.
	Physician /Medical		23a. Part1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	_Colon (	ANCER		ic or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	Due to (or as a conse	TORY	FAILURE			
V	executed n and ial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ENSIDA				
Box 68760,	tificate be exering physicien arest the burial-t		C	HYPOTH	YROIDISM	1			
P.O. Box	The law requires that the death certificate be exe ate has been signed by the attending physicien a page 2 should be detached for use as the burial-	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 Ecto	pic pregnancy er (specify)		23d. Date of de Month	elivery Day Year
rds, P	quires that in signed b		Part II. Other significant conditions con	tributing to death but not re	esulting in the underly	ving cause given in Part I.			to the cause of death?
Division of Vital Records,	sician: The law requir certificate has been si rector, page 2 should I	Completed					24a. Was an autopsy performed	? death?	utopsy findings available completion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	ocastali			ath  Check only one		
o to	Phys r this ral dir	To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		☐ ER/Outpatient 3[ 28b. Time of	DOA Other: 41 ursing I	Home 5 ☐ Residence		ecify)
sion	Attending Physician: r death. ector: After this certifica by the funeral director.	Certification;	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	Injury M	Work? 1 □ Yes 2 □ No			
Div	5 5 5 5	Certif	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	city)		28f. Location (Street City or Town, St	ate)	
	Hospital 24 hours a Funeral I etely filled	edicai	29a. Certifier 1 Certifying Phys (Crack only 2 Medical Examin	sician: To the best of my kn ter: On the basis of examin and manner stated.	nowledge, death occunation and/or investig	urred at the time, date and plac ation, in my opinion, death occ	e, and due to the cause urred at the time, date	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mon.	th, Day, Year)
		1	30. Name and address of person who con	mpleted cause of death //*	MD	D27188		7/28/2	26
	5		Savinder (C)	tuke 2 M	greef /	lace Dung	alk MI	> 2/22	2
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAR 3 1 2006	32 Registrar's Sign	nature for the				

	1		State of Maryla	ind / Depa	artment		n and M	lental Hyg	iene	16	0991	4
Physici /Medi	an	1. Decedent's Name (First, Middle, Last) Pete Calvin Lynch						2. Date of Deat Month	29 29	2006	3. Time of 1	
Examir	ner	4a. Facility Name (If not institution, give str 400D SAMARITA 5. Sociat Security Number 6. Sex	N HOSPITA	4L rs. last birthday)	Ba1	timore Year If Un Days Hou	der 24 Hrs.	8. Date of Birth	n/a	9. Birthpl	ace (State or	
Director		212-26-9959 X	<sup>A 2□ F</sup> 76	Yrs.		Days	TS NAIT.	July 18,	1929	Clark	sburg,	
ne Maryland 8a-f show	Director	MD 10b. County n/a		City, Town or Lo	2	Code		1	0g. Citizen of		1X Yes	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Itams 23a or 28a-f show eny injury or other traumatic event, Ira Madical Exactive minal be routined at enough injury or other traumatic event, Ira Madical Exactive minal be routined at once.	by Funeral	10e. Street and Number  5413 Creston Avenu  11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Le . Was Decedent Ever in Armed Forces?  1 MYes 2 Mo tt Yes, Give Year or Dates:	U.S. 13.	10f. Zip  212  Was Deced If Yes, spec	ent of Hispanic ify Cuban, Mex		ecify Yes or No- Rican, etc.)	U.S.A	A. ace - Americ ack, White, Wh	an Indian,	<u>.</u>
partitions, was yeared within 72 hours all permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or important: If Item 27 is marked other than "naturel", or injury or other traumatic evant, tra Medical Examples.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+) 3 years	(Give	kind of wor DO NOT us	int			16b. Kind of  Baltimo  Maiden Suma	ore Po	-	ınic
should be ind Mental ind Mental or marked o	To Be	Harold Lynch	Print)	19b. Mail	ina Address			ay Davis		n, State, Zip	Code)	
and 2 st leath and m 27 is n		Louise A. Lynch/W:	ife	5413	Crest	on Ave	nue, B	altimore		21214		
Department of Pages 1 Department of F Important: If Its eny injury or ot		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signuture of Funeral Service Licensed	moval from State	cemetery, cree etro Cr	emetory or o emetol 22. Name ar	ther place) CYid Address of F	acility Mi	3, 2006 ller-Digaltimore	ppel F		Home	
Physician		23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one timmediate Cause (Final disease or condition	ations that caused the decause on each line.	eath. Do not er	nter the mod	le of dying, suc	h as cardiac		rest,	0 R121+ A	Approximat Interval Bet Onset and I	ween
(e be executed with the prize of the prize o	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-	HYPERTE sequence of):	NSION							
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uires thet the signed by the d be detached	호	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying	cause given in I	Part I.		obacco use co Yes 2 ☐ No		the cause of c	
OT VICAL RECORDS, Physician: The law requires! rthis certificate has been signinal director, page 2 should be	Completed							24a. Was autor perfo 1 Yes	osy ormed?	b. Were autoprior to condeath?	opsy findings ompletion of a	available ause of
r Vital F ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpati	ient 3□ D	Other		ath (Check only of Iome 5 🗆 Resi		Other (Speci	ify)	
On Or ding Phy th. : After this of uneral d	ition: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		of	28c. Injury at Work? 1 ☐ Yes	2  No	28d. Describe	how injury occ	curred		
DIVISION or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - building, etc. (Sp.	At home, farm, pecify)	street, facto	y, office		28f. Location ( City or To		mber or Ru	ral Route Nur	nber,
UNISION OF VITAI To the Hospitel or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	sicien: To the best of my ner: On the basis of examination and manner stated.	knowledge, de mination and/or	ath occurred investigation	d at the time, da n, in my opinion	ate and place n, death occu	e, and due to the urred at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(	s)
To the within To the	Me	29b. Signature and title of certifier	year M.	D	29	OC. License nur			29d. Date sig	29/0	-	
10+1		30. Name and address of person who co	1.7		oe, Print)	SANDE AVEN !	EP MA	BALTIM				?
S Regis	itate strar	31. Date filed (Month, Day, Year)	-60									

			State of Maryland / Department of Health and N  1- Registrer  Certificate of Death	Mental Hy	rgiene () () ()	09945
			Decedent's Name (First, Middle, Last)	2. Date of De	eath	3. Time of Death
	Physici /Medic		ALEXANDER LOGAN	MARCH	I 28 2006	9:55A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Dea	th
			9907 CERVINE LANE, APT. T4 RANDALLSTOW		BALTIM	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 19. Age (In yrs. last birthday	8. Date of Bir (Month, Da		thplace (State or Foreign ountry)
	Director		579-18-1913 XIM 2 B 86 Yrs.	03/27	//1920 VI	RGINIA
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar.	tor	MD BALTIMORE RANDALLSTOWN			1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	ath w	ral	9907 CERVINE LANE, APT. T4 21133		USA	
	72 hours after death with the Maryland Inatural; or itema 23a or 28e-f show dical Exam in must be inclifted at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  US  13. Was Decedent of Hispanic Origin? (Sp. 11. Never Married 20 Marian)  14. Never Married 20 Mar	pecify Yes or No o Rican, etc.)	0- 14. Race - Am Black, Whi	
36	rs aft	by F	I Never Married 2 Married   I XI tes 2 100		Specify:	BLACK
5-003	2 hou	pe	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry
212	hin 72 an "na Medi	plet	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	king		
_	filad within Hygiana. Ither than "	Completed	12TH SHOE REPAIRMAN		HOETIGHT	SHOE CO.
g	m - 0 2	Be (	17. Father's Name (First, Middle, Last)	ne (First, Middle	, Maiden Sumame)	
Maryland 2		T <sub>o</sub>		E LOGA		
Jai	s 1 and 2 should f Haalth and Mer Itam 27 is marke othar traumatic		19a. Informant's Name/Relationship (Type, Print)  CAROLYN FORD / NIECE  19b. Mailing Address (Street and Number or Ru.	ral Route Numb	per, City or Town, State,	Zip Code) 21133
	1 and Haalth am 27 thar t		CAROLYN FORD / NIECE 9907 CERVINE LANE  20a. Method of Disposition 20b. Place of Disposition (Name of	, APT	20c. Location - City or	
ဝို	9° = 5		cemetery, crematory or other place)			
altimore,	parmit. Pag Dapartmant Importent: any injury c		Ct. Circulum of Second Continue Lineares	05/06	OWINGS M	
Ba	parmit. Daparti Importi any inj		H (X M b		FUNERAL H	
			23a. P.M. Evier the discase, or complications that caused the death Do not enter the mode of dying, such as cardiac	or respiratory a	AVE, BALT	Approximate
	Pnysician	8 1	shock, or want failure. List only one cause on each line.  Immediate cluse (Final disease or condition as the condition as th	emma	1111 di 10	Interval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	or it is	and water	res
н	Examiner		Sequentially list conditions b.		0	
	sit sit	iner	Sequentially list conditions, if any, leading to intribudiate cause. Enter Undertying Cause (Disease or injury			
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68/	ate hy:	O	d.			
ROX	daath certific a attanding p id for usa as I	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery
ň	daath a atta d for	icla	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
J.	by tha da	Physiclan/Me	9 ☐ Unknown 9 ☐ Unknown			
ທົ	gnad gnad	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part it.	23e. Did	tobacco us <i>e</i> contribute t	o the cause of death?
S. C	w raquin been si should I			المل	Yes 2□No 3□P	robably 4 Unknown
Vital Record	a taw r has be ga 2 sh	ple		24a. Was	psy prior to	utopsy findings available completion of cause of
<u>r</u>	ata pag	Completed		perfo 1 ☐ Yes	ormed? death?	2 □ No
/Ita	sician: Th cartificata ractor, pag	Be	25. Was case referred to medical examiner?	th (Check only	one)	
0	this al dir	. To			idence 6 Other (Spe	ocify)
	ling Aftar una	ertification:	Natural 5 Pending (Month, Day Year) Injury Work?	Zod. Describe	now injury occurred	
Division	or Attanding ifter death. Diractor: Aftar in by tha funa	flca	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office	28f. Location (	Street and Number or R	ural Route Number.
2	af or Attand after death i Diractor: d in by tha i	erti	4 ☐ Homicide determined building, etc. (Specify)	City or To		
	Hospital Hospital Funarai taly fillad	alc	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the	cause(s) and manner a	s stated.
	To the Hospital of within 24 hours af To the Funaral D complataly fillad it	edical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time,	date and place, and du	e to the cause(s)
	To To COT	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon.	
	X		1900 tuay 056038	/	March 30,	2000
L	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10 Noeth Chare Street Falt, Mtl. 1	un.	71771	
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	100	X140,	
	Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			
		- 7	SHAP I LUUU AMERIKA AT AT AT AT AT A AT A AT A AT A AT A			

			1 - For State Registrar	State of Maryl	and / I		rtment of H rificate of L		Re	g. No.	006	09946
E	Physici /Medio		Decedent's Name (First, Middle, Last     ANNE	P.			LEVINSON		2. Date of Deat MONth MARCH 2	8, Day 20	006 Year	3. Time of Death 6:15 A M
	Examin Funeral Director		4a. Facility Name (If not institution, give ELESY MANOR  5. Social Security Number 6. Se 579-32-6615		yrs. last bi		-	LOCATION OF DEATH LTIMORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUL . 10,			LTIMORE  place (State or Foreign  NY
		or	Usual Residence of Decedent  10a. State 10b. County		. City, Tow		ation IMORE		002.20,	1500	1	10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "netural", or Items 23a or 28a-f ehow fa Madigal Exar that mats be indiffed at	Funeral Director	MD	ROAD  12. Was Decedent Ever Armed Forces?			10f. Zip Code	21208 spanic Origin? (Spon, Mexican, Puerto		14.	of What Cour Race - Americ Black, White,	USA can Indian,
215-0036	"netural, or ltd	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grace)	1 Yes 2 No If Yes, Give Year or Dates:	16a	. Decede	☐ Yes 2 💢 No	Specify:		Spe	ecity:	WHITE
1212 b	filed Hygi Sther ent, L	Be Completed	Elementary/Secondary (0, 12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	CL	ERK	O NOT use retired,	18. Mother's Name				D.C. GOV'T
Maryland 21	2 should be and Mental le marked of aumatic even	ToB	SIMON  19a. Informant's Name/Relationship (7)		198		Address (Street a	KATIE			own, State, Zip	
Baltimore, N	Pages 1 and nent of Health int: if Item 27 iry or other ti		JUDITH COPLIN /  20a. Method of Disposition  1 [X]Burial 2 Cremation 3 [If 4 Donation 5 Other (Specify)		b. Place o	of Dispos ery, crema	ition (Name of atory or other place	EW ROAD F	Date :	20c. Locati	MD 212 ion - City or To LPHI,	own, State
Balti	permit. Pag Department: Importent: f any Injury o		21. Signature of Funeral Service Licens	•		8	Name and Addres	TERSTOWN	OL LEVIN ROAD -	PIKES		MD 21208
68760,	hysicien and hysicien and hysicien and hysicien and hysicien and hysicien and the burial-transit	edicai Examiner	if any, leading to immediate Cause (Disease or injury		S C V	D of):	the mode of dying	g, such as cardiac d	or respiratory arre	est,		Approximate Interval Between Onset and Death
O. Box	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)			23d.	. Date of delive Month	ery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not	t resulting	in the und	dertying cause give	en in Part I.	23e. Did tob	_/		he cause of death?
al Recc		Completed	as W							y ned? 213 No		opsy findings available impletion of cause of
Division of Vital Records,	ending Physicath. Pr: After this he funeral di	Certification; To Be	27. Manner of D ath  1 Selatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		utpatient Time of Injury	28c. Injury Work	4 AN Nursing Ho	me 5 Reside 28d. Describe ho	once 6 🗆	ccurred	
DIX	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		4 Homicide determined  29a. Certifier Martifying Phy	building, etc. (Sc	bec <i>ify)</i>	e. death	occurred at the tim	ne, date and place,	28f. Location (St City or Town	n, State)	d manner as s	tated
)	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of exar and manner stated.	mination a	nd/or inve	estigation, in my op	pinion, death occur	red at the time, da	ate and pla	ice, and due to	Day, Year)
	6		30. Name and address of person who can the company of the company	ompleted cause of death	(Item 23a)	(Туре,	Ant) 717 (	PARK	14E16	HTS	NUE	21215
ŧ	Sta Registi		31. Date filed (Month, Day, Year)	Registrar's S	Signature	Acres	la p					

			For State	State of Maryland	/ Depa	artment of He	ealth and	Mental Hy		nns	1991.7
			Registrar	acti	Cei	tificate of D	Death	2. Date of De.	Reg. No.		3. Time of Death
	Physici		1. Decedent's Name (First, Middle, I	1 00.				Month 3	Day B	2006	1554 M
	/Medic Examin		4a. Facility Name (If not institution, of	rive street and number)		4b. City, Town, or ROCKVI	Location of De	eath		County of Death	mery
17	Funeral Director			Sex 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	Irs. 8. Date of Birl In. (Month, Da	th ly, Year) 195.	9. Birth	place (State or Foreign ptry) Sachusetts
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	1 .			<u> </u>			0d. Inside City Limits
	the Mar	ector	mo mont	Jomery Rock	VII	10f. Zip Code			10g. Cit	izen of What Cou	1 ☐ Yes 2 No
	23a or	Funeral Director	1106 Gilbert	Road		2085			US	SA	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f ehow event, the Medical Examinal must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 Ho	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		14. Race - Americ Black, White, Specify: (W)	
15-0	within 72 ho ene. then "natur te Medical	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of	working		ind of Business/In	, ,
1212	filed with Hygiene. other than		Elementary/Secondary (0-12)	College (1-4or 5+)	Wel	der	18 Mother's	Name (First, Middle,	L	ted Asso	ciation
land		To Be	Joseph F. Mal					a Alice		-	
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship Teresa Malone	1.7		stephole	1	Rural Route Number			
ore,			20a. Method of Disposition 1 □ Burial 2 ☐ Gremation 3	20b. Plac	e of Dispo	sition (Name of matory or other place	9)	Date 7	20c. Lo	ocation - City or To	own, State
Baltimore,	그 등 본 층	- 1	*4 □Donation 5 □ Other (Special Service Line)	7-4-0	apec	Ne Cremati 2. Name and Addres	01 9	lopf Funer	rsel	tsville	INLD Igh Servicos
B	Depar Impor		State State	2 maj 35° complications that caused the death.	6 9	33 Grist		Versprin		11905 an	Approximate
	Physician /Medical Examiner	ner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to or as a consequer  b. Due to (or as a consequer)	orce of):	cardio il ble	Vasci	ular dis	EAS	e	Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequer	nce of):						
.O. Box 68	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the base.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	□Ectopic pregnancy □ Other (specify)				23d. Date of deliv Month	ery Day Year
٥.	ires that the de signed by the a d be detached f	þ	Part II. Other significant condition	s contributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did t	1		he cause of death?
Records,	law requir nas been si e 2 should l	Completed						24a. Was	an	24b. Were auto	opsy findings available impletion of cause of
tal R	siclan: The law certificate has b irector, page 2 s	a	25. Was case referred to medical				26. Place of	1 ☐ Yes  Death (Check only to	2 X No		21) No
of Vital	Physiclan: rthis certific ral director,	To B	examiner? 1 ≥ Yes 2 □ No	- Janes - I	VOutpatie		4   Nursin	ng Home 5 X Hesi 28d. Describe			fy)
ion	ath. or: After	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	(Month, Day Year) ition	8b. Time o Injury	Work	(? Yes 2 □ No	Zod. Describe	now inju	ry occurred	
Division	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		e, farm, st	reet, factory, office		28f. Location ( City or To		nd Number or Rur a)	al Route Number,
	To the Hospital or Attending Physiclen: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		Physician: To the best of my knowle xaminer: On the basis of examination and manner stated.							
	vithir To th	Me	29b. Signature and title of certifier	Tomsko Ma	9, Th	29c. License	5/9/4	9	29d. Da	ite signed (Month)	Day, Year) , 2006
	W		30. Name and address of person w	ho completed cause of death (Ite 2	النب	e Pike, 6	3-100,	Rockvill	le, 1	MD 20:	352
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 1	32. Registrar's Signatur	re		/ '				
DH	IMH 17 Rev 1/2	2001		Janes 10	DRIGIN	IAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 28 Marci 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner aradise ssisted IVING 1 MOSC (In yrs. last birthda) Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign 5. Social Security Number 7. Age **Funeral** Days Min. 1 M 2 □ F Hours N 6828 Director any Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits worde ! other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director 28a-f Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or rick 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No f Yes, Give Year or Dates Specify: Completed by 3 Widowed 4 □ Divorced ac natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) arr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental I ant: If item 27 is marked o May den 1 a 19a. Informant's Name/Relationship (Type, Print) (Daug http:) 19b. Mailing Address (Street and Number or Rural Route Number, City pr Town, State, Zip Code) May din 5 a biggs of Disposition (Name of cometery, crematory or other place) Road Orehard Balton 21229 MD Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ō 1 Burial 2 Cremation 5 Other (Specify) Entenhment Department of Important: If any njury or once. 3 06 rbutus Men . Park 22. Name and Address of Facility 21. Signature of uneral Service Licens Funeral Home . A. 2222 W. Balto. MD 21216 rth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arreig eAVS DIONAMU /Medical Due to (or as a consequence of): Examiner perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate has 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPice this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, within 24 hours after death. To the Funeral Director: A the filled in by Hospital completely To the

State Registrar

Medicai

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

FRANCIS X. STRAIN 32. Regetrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

eli

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D44715

3.30.06

29d. Date signed (Month, Day, Year)

ST PAUL ISACTIMONE MD

			1 - For State of Mary	land / Depa	artment of H	lealth and	Mental Hy	9	09949
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physici		. Pauletta McMillan				Month March	Day Year 2006	E 20 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of De	L
			3921 Conowingo Road		Darlin	aton		Harf	ford
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		th 9. B	irthplace (State or Foreign Country)
ш	Director		243-48-9393 1□M 2√2 F 73	3 Yrs.	Months Days	Hours Min	Feb. 2	7, 1933 No	rth Carolina
	p J		Usual Residence of Decedent	Oit T					
	aryla shov	7	10a. State 10b. County 10c	c. City, Town or Lo	ocation				10d. Inside City Limits
	8a-f	ctc		Darlingt					1 ☐ Yes 212 No
	vith th	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What (	Country?
	s 23e	ral	3921 Conowingo Road		21034			USA	
	er de Item:	une	11. Marital Status  12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ( n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - An Black, Wh	nencan Indian, nite, etc.
36	rs aft	by F	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【No If Yes, Give 7 Garden 1 ☐ Yes Give 7 Garden 1 ☐ Yes 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 3 ☐		1 ☐ Yes 2 🔀 No	Specify:		Specify:	7 .
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Madical Examinative rodified at	ed	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Busines	Vhite s/Industry
75	n "n	plet	(Specify only highest grade completed)	/Give	kind of work done of DO NOT use retired	during most of we	orking	700.11.74 0.000.700	amassiy
2	d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Home	maker			Own Home	
	othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Surname)	
Maryland	Ald be Alenta rked ric ev	To B	Horton Bower Taylor			Pearl I	ou Teste	erman	
ar	sho and h s ma	•	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or R	ural Route Numbe	er, City or Town, State,	Zip Code)
	and 2 paith n 27 i		Carl B. McMillan / Husband	3921	Conowing	o Road,	Darlingt	on, Maryla	and 21034
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23e or 28a-f show amy injury or other traumatic event, the Madical Examinating the notified at once.		20a. Method of Disposition 1	Ob. Place of Dispo	osition (Name of matory or other place	e)	Date	20c. Location - City of	r Town, State
<u>Ĕ</u>	Pag nent ant: I		'4 □Donation 5 □ Other (Specify)	Bel Air J	Memorial	Grdns 3-	-31-06	Bel Air, N	Maryland
alt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22	Name and Address F	s of Facility			•
<u> </u>	89 = 29		Mussell Sly		1317 Coke	sbury Ro	pad, Abir	ngdon, Mary	land 21009
г			23a. Part1. Enter the disease, or complications that caused the caused, or heart failure. List only one cause on each line.	death. Do not ent	ter the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lahi	Small	colling	ng cam	(0)	Onset and Death
	/Medical		resulting in death)  Due to (or as a con	nsequence of):	-1110411	CKILLOU	19 001		HAIONING
	Examiner		Sequentially list conditions. b.				0		
7	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):					
V	and trans	Examiner	that initiated events c.						
60,	ate be executed hysician and the burial-transit		Due to (or as a con	isequerice or).					
687	0 0 0	dlcal	d						
	attending p	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	egnancy				23d. Date of d	aliven
Вох	at the death certi I by the attending stached for use a	clar	in the past 12 months?		Ectopic pregnancy Other (specify)			Month Month	Day Year
o.	y the	ysi	1 Yes 2 No 9 Unknown 9 Unknown						
۵.	res that signed b be deta	by Pr	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco ase contribute	to the cause of death?
rds	serines n sign						1 1	s 2 □ No 3 □ F	Probably 4 Unknown
Records,	w require been sig should b	lete					24a. Was	an 24b. Were a	autopsy findings available
Re	he lav e has age 2	Completed					autop perfor	prior to rmed? death?	completion of cause of
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical			26 Place of Do	1 ☐ Yes ath (Check only o	20 No 1 Ye	s 213/No
>	ysician: The is certificate hadirector, page	To B	examiner?	2 ER/Outpatien	nt 3 DOA Othe	NP.	./	lence 6 □Other (Sp	ecify)
Division of	g Phys er this eral di		27. Manner of Death 28a. Date of Injury					now injury occurred	ouny
0	ath. r: Aft ie fun	ate	1 SNatural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	ar) Injury		r res 2 □ No			
<u>X</u>	or Attanding latter death. Director: After in by the funer	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or F	Rural Route Number,
	tel or s afte al Dii	Certification;	building, etc. (5)	recity)			Only of You	m, olate)	
	To the Hospitel or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only (Ch	knowledge, death	n occurred at the tim	e, date and place	e, and due to the	cause(s) and manner a	is stated.
	the P the P		and manner stated.	Timation arrows in					
	To To	Σ	29b. Signature and title of certifier		29c. License			29d. Date signed (Mor	
			Stand N	D		5530		3-28-	06
	6		30. Name and address of person who completed cause of death	-	Print)	D =1 -	- 0.0.	10111	
			5 · SIUA SALLAM, 602, 5 · A7 31. Date filed (Month, Day, Year) 32 Registrar's S	ionature		Belaly	MD2	1014	
	Sta Registra	-	MAD 9 1 2000	Mr des	will .				
			MAKO I ZUUD SAGARA	Je 1-1					

			For Stata Registrar	State of Mai	yland / l		rtment of F <i>tificate of</i>	lealth and N <i>Death</i>	_	giene Reg. No.	106	19950
	Division		1. Decedent's Name (First, Middle, Last)						2. Date of De.	ath	V	3. Time of Death
	Physici /Medio		Olive Geraldi	ne M	oyer				March 2	Day 20	006 Year	9:40 P M
	Examir		4a. Facility Name (If not institution, give str	eet and number)			4b. City, Town, o	r Location of Death		4c. C	County of Death	
			83 Garner Avenue				Waldorf				Charles	
	Funeral Director		281-46-9608	7. Age (	In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Mar. 19	h y, Year)	Count	* *
	and and		Usual Residence of Decedent  10a. State  10b. County		Oc. City, Tow	n or Loc	ation				10	Od. Inside City Limits
	Mary f sh	ō	PA Somerset		Centra:	1 04	+					1 ☐ Yes 2 🔀 No
	28a	Director	10e. Street and Number		ochera.	T 01	10f. Zip Code			10g. Citize	en of What Count	try?
	h with		280 North Avenue				1592	26		USA		•
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or iteme 23a or 28a-f show event, the Madical Examiner must be motified at	by Funeral	11. Marital Status 12  1 Never Married 2 Married 3 Xwidowed 4 Divorced	. Was Decedent Ev Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cubin	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	. 14	4. Race - America Black, White, e Specify: Whi	etc.
5-0	72 h	etec	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a.	Deced	ent's Usual Occup	ation during most of work	dina	16b. Kind	d of Business/Ind	ustry
2	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. D	O NOT use retired	d)	9			
2	filed w Hygier ther ti		8		H	lome	maker				n Home	
anc	ntal H	Be	17. Father's Name (First, Middle, Last) Charles Henry Deck	or				18. Mother's Nam				
ž	should and Men marke umatic	ို	19a. Informant's Name/Relationship (Type		101	A 4 - 10 -	A 1.1 (O)		rene Fl			
Ma	nd 2 solith an 27 is r		, , , ,	•				an <i>d Number or Rui</i>				Code)
စ်			Matthew Moyer - So  20a. Method of Disposition	H	20b. Place of	Dispos	Havernil ition (Name of atory or other place	1 Road, T	Winsbur Date		I 44087 ation - City or Tov	wn. State
JOI	e = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State				1 2 / 20	/06			
뵬	nit. Pa cartmen ortant: njury	1	21. Sign ture of Funeral Service Licensee	11	KICHI		Cemetery	ss of Facility Me			stown, P	'A
ä	permit. Deporte Importe any nju		1 Jannis (To	Uneu	_			m Ave., V			15963	
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the	e death. Dor	not ente	r the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Que to (or as a	consequence	of):	7000	1 200	0 7			41.72
п	Examiner		Sequentially list conditions b.	Congr	stu	Ori	Har	7/200	Sund	3	*	61 KS
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.O. Box	To the Hospital or Attending Physicien: The law requires that the death certii within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at tin 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)			23	d. Date of deliver Month [	y Day Year
<u>د.</u>	s that ned b e deta	y P	Part II. Other significant conditions contri	outing to death but	not resulting in	the un	derlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
g	quire; n sig uld be	g pa							1 🗆 Y	es 2 🕽	o 3□Proba	ıbly 4 ∐Unknown
Vital Records, P.	The law reate hes bee page 2 sho	Completed							24a. Was autop perfor 1 Yes	sy	prior to com death?	sy findings available pletion of cause of
/Ita	lcien. Sertific Sector.	Be	25. Was case referred to medical examiner?	=ital.				26. Place of Deat				
5	Physi this c	٩	1 192 5 5 6 40	pital: 1   Inpatient				4 🗀 Nursing Ho			Other (Specify)	)
Division of	Jing A	5	- gor tatalai	28a. Date of Injury (Month, Day Y	ear) 28b. I	ime of njury	28c, Injury Work		28d. Describe h	ow injury	occurred	
2	ttendi death. ctor: A y the fu	lica ta	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home, far	rm etro		Yes 2 □ No	28f Location /9	troot and	Number or Rural	Bouts Number
<u>&gt;</u>	s after al Dire ed in by	Certification:	4 Homicide determined	building, etc. (	Specify)	im, stie	et, ractory, office		City or Tow		NUMBER OF HUIST	noute vulliber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical	29a. Certifier   1 Certifying Physic   2 Medical Examiner   Medical Ex	an: To the best of r : On the basis of ex and manner state	tamination ape	, death	occurred at the tinestigation, in my o	ne, date and place, pinion, death occuri	and due to the ored at the time, or	ause(s) ar	nd manner as sta lace, and due to	ited. the cause(s)
	To To To	2	29b. Signature and title of certifier	1 M	m		29c. License	number	29	29d. Date	signed (Month, D	Pay, Year)
	125		30. dress of per on who com	pleted cause of deal	h (Item 23a) (	Туре, Р	rint)	1	1		1124	106
-	U		31. Date filed (Month, Day, Year)	MAT	SEN	N	NO	NAUD	UNLY-	· M	S. M	0603
	Sta Registra		MAR 3 1 2000	32. Segistrar's	Signature	10/04	des					

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if term 27 is marked other than "netural", or iteme 23a or 28a-f show any jiury or other traumatic event, the Modical Examinating the notified at once.	
about 6	Physician /Medical Examiner	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

		1 – For Registrar	State	e of Maryl			rtment tificate					giene () (	16	0995	precinities
Physicia		Decedent's Name (First, Mid  John	ddle, Last) G .		Me	tzg	er				2. Date of Dea March	ath 28, <sup>Day</sup> 200	6 <sup>Year</sup>	3. Time of Dear 16:58	h M
/Medica		4a. Facility Name (If not institu	tion, give street an	d number)			4b. City, T	own, or	Location	ol Death		4c. County			
LXUIIIII		Baltimore-Was	hington	Medica1	Ctr.		Gle	n Bu	rnie			Ann	e Aru	ındel	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1		If Under		8. Date of Birth	h	9. Birth	place (State or For	eign
Director		213-30-4467	1 ☑ M 2 🗆	72	,	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Sept.	5,T933	Mary	Tand	
		Usual Residence of Deceden1													
No W	_	10a. State 10b. Cour	nty	10c	. City, Towr	or Loc	cation						,	10d. Inside City Lin	
Pa-E	5	Maryland Ann	e Arunde	L P	asade	na								1 □ Yes 2 ⊡	170
or 2	Directo	10e. Street and Number	. D. 1				10f. Zip (		10			10g. Citizen of			
238		1222 Meadow V						2112					.S.A.		
Itom Der II	Funeral	11. Marital Status	Arme	Decedent Ever in differences?	in U.S.	13. V	Vas Decede Yes, speci	int of His by Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		ce - Ameri ck, While,	can Indian, etc.	
0	by F	1 ☐ Never Married 2 Ø M 3 ☐ Widowed 4 ☐ Divord	If Ye	res 2 □ No s, Give or Dates:		1	☐ Yes 2	No	Specify:			Specif	y: WH	ite	
a in in			lent's Education	or Dates.	16a.	Deced	lent's Usual	Occupa	tion	_		16b. Kind of B			
	Completed	(Specify onfy hig	hest grade comple			(Give I	kind of work OO NOT use	done d	uring mos	t of worki	ng			adony	
e tra	E	Elementary/Secondary (0-12	N/Z	ge (1-4or 5+) A	į		Self	Empc	1yed			Elect	ricia	ın	
oth oth	0	17. Father's Name (First, Midd	le, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Suman	ne)		
Aenta rrked tic e	108	Gilbert	Fred	erick	Me	tzg	er		Myrt	le	I	rene	S	purrier	
s ma		19a. Informant's Name/Relation					_				l Route Numbe				
alth er tre		Barbara A. Me	tzger (W:	ife)	1	222	Mead	ow V	7iew	Road	Pasadei	na, Mar	yland	21122	
a te		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic	- 2 DR		b. Place of cemeter	Dispos y, crem	sition (Name	of er place	9)	D	ate	20c. Location	City or To	own, State	
ant: f		4 □ Donation 5 □ Other			Cedar	Hi1	1 Cem	eter	y ¦	4/1/0	06	Brook1	yn Pa	rk MD	
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Servi	ce Licensee			22 M	Name and IcCuII	Addres:	s of Facility	ak Fi	ıneral l Pasadeı	Home, P	.A.	21122	
		23a. Part. Enter the disease,	or complications t	hat caused the c	death. Don								y Idiio	Approximate	-
ysician		strick, or heart failure. L Immediate Cause (Final	ist only one cause	1	NIM	A	OF		1110	16				Onset and Death	
Medical		disease or condition resulting in death)	aDu	ARCI e to (or as a con					241	<u>( ) </u>				17200	
aminer					,	•									
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Du	e to (or as a con	sequence	of):									_
ransı	Examiner	Cause (Disease or injury that iniliated events	) c												
ien al urial-t		resulting in death) Last	Ou	e to (or as a con	sequence	of):									
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tend or use	an/	23b. Was decedent pregnant in the past 12 months?		s, outcome of pre ive birth 2 $\square$ f		3□	Ectopic pre	gnancy					te of delive	ery Day Year	
the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at time Inknown	ol death	5 🗆	Other (spe	cify)				INIC	21111	Day Toal	
d by	5	Part II. Dther significant cond	itions coatabution	to dooth but out	eseultie – ie	15	4-4 :		- in Dod I		22a Didaa			ne cause of death	
bed l	2	Patt II. Ditier significant cond	itions contributing	to death but not	resuling in	me un	idenying ca	ıse give	n in Parti			es 2 🗆 No		ne cause of death pably 4 ⊟Unkno	
hould	še											es 2   NO	3   100		
has b	ompieted		·	-							24a. Was a autop:	an 24b	Were auto	psy lindings availampletion of cause	able of
cate . pag	5										perfor 1 Yes		death? 1 🗌 Yes	2 No	
ector	g	25. Was case referred to medi examiner?	ical Hospital:			_		Otho		of Death	(Check only or	1ө)			
this all dir	<u> </u>	1 Yes 2 No		1 Inpatient	2 DER/Out	·			4 🗀 140		ne 5 Resid			ý)	
After funer	5	1 ☐Matural 5 ☐ Pen	ding (	Month, Day Yea	r) 28b. T	jury	м 20	c. Injury Work	ai ? ′es 2		28d. Oescribe h	ow injury occur	гөа		
deat ctor: / the	Ca	3 ☐ Suicide 6 ☐ Cou	stigation Id not be 289 F	Place of Injury - A	At home lar	m etre			65 2	140	281 Location /S	treet and Numb	ner or Pur	al Route Number,	
Dire Dire	erilication	4  Homicide dete	ermined 289.	ouilding, etc. (Sp	ecify)	111, 51.10	oct, ractory,	Ollinos			City or Tow		767 07 711176	111001011011	
filled	=   =	29a. Certifier 1 Certif	ying Physician: T	o the best of my	knowledge	death	occurred a	t the time	e. date an	nd place, a	and due to the c	ause(s) and ma	anner as s	tated	
within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medic one)	ai Examiner: On t	he basis of exam manner stated.	nination and	/or inv	estigation, i	n my op	inion, dea	th occurre	ed at the time, o	late and place,	and due to	the cause(s)	
To th	ĕ.	29b. Signature and title of cert					29c.	License	number		2	29d. Date signe	d (Month,	Day, Year)	_
		▶ Wtrma	eMI) AG	tendrix	) Do	Tor	1	12	-168	4		3/29	120	006	
0+1		30. Name and address of pers	on who completed	cause of death	Item 23a) (	Type, F	Print)	WY	P	7810	RNA	MO	9112	2	
Stat	9	31. Date liled (Month, Day, Ye	ar)	32 Registrar's S	ignature	B	AD -		<u>'</u>				~ 112	9	
Registra		MAR 3	1 2006	A SELARIO	13.		BASEL								
		24.24 60.5				-									

		1 - For State Registrar	State of Maryland	Jack Indelible Ink. Ensure 4, 4/6/06 IT 17 Department of Health and Certificate of Death			09952
		Registrar  1. Decedent's Name (First, Middle,	Last)	Certificate of Death	Reg.	No.	3. Time of Death
Physic		John		avage IRI	March 24	Day 2006 Yeer	3:04 P
/Med Exami		4a. Facility Name (If not institution,		4b. City, Town, or Location of De		4c. County of Death	
		118 Limestone R		Hancock		Washing	ton
Funeral Director		5. Social Security Number  207-34-0190  Usual Residence of Decedent	3. Sex. 12 M 2 □ F 7. Age (In yrs. la 5 9	Ast birthday) If Under 1 Year If Under 24 F Wonths Days Hours M	Irs. 8. Date of Birth (Month, Day, Ye	947 Pen	place (State or Foreintry) nSylvani
death with the Maryland me 23a or 28a-f ehow rmust be notified at	tor	10a. State 10b. County Wieh	ing ton Co. 10c. City.	Town or Location Belle Vern	on		10d. Inside City Limi
th with the 23s or 28s	ai Director	10e. Street and Number Bro	ad Ave	101. Zip Code 15012	10g.	Citizen of What Cou	intry?
s 1 and 2 should be illed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f shouther traumatic event, the Modical Examiner must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ⊅ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>13. Was Decedent of Hispanic Origin?         If Yes, specify Cuban, Mexican, Pt         1 ☐ Yes 2 No Specify:</li> </ol>	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: U	
72 ho	Completed	15. Decedent's	Education grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of	working 16i	b. Kind of Business/II	ndustry
within 7 ene. then "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	HOIKING	State of	Ivana
12 should be filed within and Mental Hygiene. Fle marked other then "		17. Father's Name (First, Middle, Li	6 years	7 eacher	Name (First, Middle, Mai		71
t be find He of ot	Be			R: mar	, ,	-d	
should od Me mark matic	2	19a. Informant's Name/Relationshi		19b. Mailing Address (Street and Number or	1	ity or Town, State, Zi	p Code)
and 2 salth ar		Dhia Marco	1	1408 Calander C	t, Richmon	_	3235
of Health of Health ltem 27		20a. Method of Disposition		ace of Disposition (Name of metery, crematory or other place)	Date 20d	. Location - City or T	own, State
Pages nent of int: ff It iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State	tro Crematory 3	29-06 (	atons in	ile ma
permit. Pages 1 a Department of Hea Important: if Item any Injury or othe		21. Signatur Fureral Service Li	consee Thanh	22. Name and Address of acility  Gan, P., march	FreditiLTE	in Pass one Baet	o.md, 212
		23a. Part 1 Enter the disease, or c shock, or heart failure. List of	omplications that caused the death.	. Do not enter the mode of dying, such as card			Approximate Interval Between
Pnysician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. Cirrhosis of 1:				Onset and Death
Examiner		Sequentially list conditions,	b				
pe ils	luer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of			
executed en and urial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):			
sicien buris							
certificate be nding physicie use as the bu	edic						
eath certificate be ettending physicié for use as the bu	M/C	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome of pregnar			23d. Date of deliv	very
D 0 D	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de			Month	Day Year
t the	Physician/Medical	9 Unknown					
signed I	ρ	Part It. Other significant condition	s contributing to death but not resu	Iting in the underlying cause given in Part I.		co use contribute to	
w requir been si should	eted				_ 1 ☐ Yes	2 € No 3 ☐ Pro	babły 4 Unkno
e law hasb e 2 st	Completed				24a. Was an autopsy performed	24b. Were aut prior to co	opsy findings availa ompletion of cause
sicien: The law certificate has t irector, page 2 s					iv Yes 2□		2 No
Physicien: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	0.1	Death (Check only one)		
Phys r this ral dii	5. To	1 ★ Yes 2 No  27. Magner of Death	1 _ inpatient 2 _ E	-NOutpatient 30 DOA 4 Nursin	g Home 5 Residence		(h) at scer
ding th. : Afte	tion	1 Anatural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year)	28b. Time of Injury M 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No			
Attending ir death. ector: Alter by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Ptace of Injury - At hor	me, farm, street, factory, office	28f. Location (Stree	t and Number or Rui	al Route Number,
s efte	Certification:	4 Homicide	building, etc. (Specify,	)	City or Town, S	itate)	
To the Hospital or Attending Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my know xaminer: On the basis of examinati and manner stated.	vledge, death occurred at the time, date and pl on and/or investigation, in my opinion, death o	ace, and due to the caus courred at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
To the within To the Comp	W	29b. Signature and title of certifier	In Sheel	O.C.M.E.		Date signed (Month)	
		30. Name and address of person w	the completed cause of death (Item	444	Do1+	M1 1	21201
2)1		M // // // // // // // // // // // // //				IVIONTTIONA	7 1 77 11
2)1		31. Date filed (Month, Day Year)	D. KOR EU  32 Registrar's Signate	111 Penn Street,	, bartimore,	, maryrand	21201
2) Sr Regis	ate trar	31. Date filed (Month, Day, Year)	32 Registrar's Signate	ure	, bartimore,	ratytano	21201

		,	1 - For State Registrar	State of N	Maryland		rtment tificate				Re	g. No.	306	09953
	Physici	an	Decedent's Name (First, Middle,  Polyant Moore)	Last)							2. Date of Deat Month MARCH	h Day	Year	3. Time of Death
	/Medio	ai	Robert Moore  4a. Eacility Name (If not institution,	give street and number	or)		4b. City. 1	own, or	Location o	of Death	MARCH	4c. (	County of Death	06.17
	Examin	ier	GMD SAMAR	STAN HO	SPITI	44	1	BAK	TIM	ORB			NI	4
	Funeral		5. Social Security Number		Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		226-34-8492	1 <b>X</b> □M 2□F	75	Yrs.	Working	Duyo	110010		01-01-19		Virgi	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limits
	Maryl sho	호	MD NA			Balt	imore							1X Yes 2 ☐ No
	r 28a	irec	10e. Street and Number				10f. Zip				1	0g. Citiz	en of What Cou	intry?
	th wit	a D	6116 Belair Road						21206				USA	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Haaith and Mantal Hygiene.  If item 27 is marked other than "natural; or items 23s or 28s-f show or other traumatic avant, the Medical Evan	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 XDivorced	12. Was Deceder Armed Forces ad 1 \( \) Yes 2 [ If Yes, Give Year or Dates	s? ⊒No		Vas Deced fYes, spec I□Yes 2		spanic Orig , Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		4 Race - Ameri Black, White, Specify: Black	, etc.
9	2 hou	ted	15. Decedent	s Education		16a. Deced	lent's Usua kind of wor			t of working		16b. Kin	d of Business/Ir	
21215-0036	within 7 ene. than "n the Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	DO NOT us	e retired)	uring mosi	OF WORKE	ig	т	·	
2	e filad wi ti Hygien othar th vant, the	S	3		Ę	1	nstall	er	40. 44-45-	A. M	1000 A 4 (1-1-1) - A		encing	
and	ould be fil Mantal H arked otl atic avan	To Be	17. Father's Name (First, Middle, L	unknown					18. Mothe		(First, Middle, M ry Moore	naiden s	oumame)	
Maryland	2 shou and M Is mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)			•				Route Number	City or	Town, State, Zi	p Code)
	1 and Haaith am 27 ther tr		Ayana M. Moore/ Dau	ghter	20h Bli						imore, MD	200 100	ation - City or T	Court State
altimore,	Pagas 1 nant of H ant: If ita ary or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		te Zoo. Fi	ace of Dispo metery, cren	natory or of	her place						
Ħ	t. Partmar rtant rtant		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Garr	ison Fo	rest V			)4-05 <del>-</del> 1	06 0	wings	s Mills, I	MD CIP
Ba	Dapa Dapa Impo any ir		Humla	gove						•	N. Gilmo	r St.	Baltimo	re, MD 21217
8760,	death certificate be exacuted  Exam  Medical  e attending physician and d for usa as the burial-transit	dicai Examiner	23a. Part. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any Learning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence a consequence as a cons	ence of):					ARCTIO			Interval Between Onset and Death (JUKUOW R.)
.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3□	Ectopic pro Other (spe					2	3d. Date of deliv	very Day Year
<u>α</u>	juires that the n signed by th ild be detache	by	Part II. Other significent conditio	s contributing to death	n but not resu	Iting in the u	nderlying ca	use give	n in Part I.			acco us		the cause of death?
Vital Records,	The law requires ata has been sign page 2 should be	Completed									24a. Was a autops perform	у	prior to co death?	opsy findings available ompletion of cause of 2 \square
/ita	ysiclan: Th	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only on			
of	ding Phys h. After this funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Ir		PVOutpatier 28b. Time of Injury		3c. Injury Work	at Nu	2	ne 5 Reside 28d. Describe ho			ify)
Division	fter c lirac in by	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 286. Place of	Injury - At hor etc. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (St City or Town		l Number or Rui	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical (		Physician: To the be exeminer: On the basis and manner	of examinati									
	To the To the Comp	Me	29b. Signature and title of certifier	5 //				License		-			signed (Month	
)			bleph.	-	in	P	H	14	26	58	1	MAR	ech 28	,2006
	7		30. Name and address of person of the state		f death (Item	23a) (Type,	Print) 5	691	LOC	HK	AVEN	Bo	ULGVBA	7006 D
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 2	100	strar's Signat	ure	W.	111	11111	- ICAN		<i>y-</i> /		

			1- State of Maryland / Department of Health and N Certificate of Death		giene Reg. No. 006	09954
	Dhusiai	÷	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ith Day Year	3. Time of Death
	Physici /Medio		PASIR MEMUR	03	29 2006	1946 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
-	Funeral	C . m	UNIVERSITY SUMPOR 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
*	Director		221-98-5237 1MM 20F 20 Yrs. Months Days Hours Min.	(Month, Day	7, Year) Cou	ntry)
	P.		Usual Residence of Decedent	1000 23		/
	arylar show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Me M	Director	MARYLAND Cecil Elkton			1 ☐ Yes 2 ₹ No
	a or		10e. Street and Number  200 GIEN CICCLE DRIVE  21921		10g. Citizen of What Cou	ntry?
	leath ns 23	era		necify Yes or No-		can Indian
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show polical Examination must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent of Hispanic Origin? (St. If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 Yes, Give 1 Yes, Specify: 1	Rican, etc.)	Specify:	
9	72 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
215	within 7 ene. than "n	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	king	11.01.	
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nd	be filed tal Hyg of other	Be		40	Maiden Sumame)	,
3	Men Marke Marke	မ		1214c		AN
Maryland	s 1 and 2 should t Health and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru.	1-11.	1 1 11-	
-	1 and Heath		20a. Method of Disposition  20b. Place of Disposition (Name of	-	20c. Location · City or T	21921
Baltimore	9 - = 5		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	,	41 6 1	-
	F 6 3			rill ac	MulatyA	
ä	permit. Departimporti		21. Signature of Fuperal Service Licensee  22. Name and Address of Facility  Joseph N. Z. Ann	SINO S	- BAlto 1	1 Horac 40 21224
4			23a. Part. Enter the disease or come ations that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List of one cause on each line.	of espiratory arr		Approximate Interval Between
	Fnysician :		Immediate Cause (Final disease or condition	44	EXAM	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of).	WE Ch		
59	Examiner		Sequentially list conditions.	WED EX	· P	
7	D #	iner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PBbs.	,	
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687	physics the l	dicai	d			
Вох	death certific attending play of for use as t	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	arv
ğ	death certific e attending p id for use as	Physician/Me	in the past 12 months?  1		Month	Day Year
0	the che	hys	9 ☐ Unknown			
s, P.	requires that een signed b hould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
rd G	w require been si should b	led		1 🗆 Y	es 2□No 3□Prol	bably 4 Unknown
9	S S S	pie		24a. Was a autops		opsy findings available impletion of cause of
<b>E</b>	The ate h page	Completed		perform	med? death? 2 No 1 ☐ Yes	
/ita	ician: Th certificate rector, pag	Be	examiner?	th (Check only or	ne)	
of Vital Record	Physician: this certific	2			ence 6 Other (Special	(y)
E	ding l	- Lo	27. Månner of Death 1 □ Natural 5 □ Pending (Mgnth, Day Year) 2 MT Accident investigation 28a. Date of Injury (Mgnth, Day Year) 1 Natural 1 □ Natural 27. □ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	S-Siscipt In	ow injury occurred of	Can which
Division	if or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Thiury - At home, farm, street, factory, office	28f. Location (S	treet and Number or Run	Al Boute Number
D.	after after Dire	Certification:	4 Homicide building, etc. (Specify)	City or Town	n, State) Blue Ba	ll and Leca's
	Hospital 24 hours a Funeral D stely filled i		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the c	ause(s) and manner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one)  and manner stated.	rred at the time, d	late and place, and due t	o the cause(s)
	To the l within 2 To the l complet	Σ	29b. Signature and title of certifier	2	29d. Date signed (Month,	Day, Year)
7	\	<	1 00 (CASET 1 HOWHS DW.) 1741 +643	27	5/50/6	•
	1χ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21/25	l	
200	V \		22 So-M Green G. BACTIME, M.S. 31. Date filed (Month, Day, Year) 32. Days strars Signature	,,,,,,	•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a PI line 5 perMD, C853, 3/31/06 TT State of Maryland / Department of Health and Mental Hygiene 09955 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Matercik March 06 : ZJAM Frances 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hapkins Bayview Medical Contor 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 9, 1917 Baltimore City Baltimore City Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2/□F Director PΑ 213-12-0077 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show other then "neture!", or iteme 23a or 28a-f ehov vent, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☐ No Director Baltimore Dundalk MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3467 Dunhaven Rd. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give <sup>∆</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ent: If item 27 ie marked other then "neturel", or Ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proofreader Lord Baltimore Press 8 item 27 is marked other other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margie M. Martin Todd Wilson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Joe Mateycik - Son 3467 Dunhaven Rd, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Depertment of importent: If eny injury or soce. 4 Donation 5 Other (Specify) Bayview Crematory 3-28-06 | Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Sorvice Lisensee JAK Ha P.A., 2134 Willow Spring Rd, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Perforation of 4 days Physician intestine disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hospital or Attending Physicien: The law requires that the death certificate be execuled anding physicien and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 20 No 1 Yes 1 ☐ Yes 2 No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Within 24 hours after death.
To the Funeral Director: Aft death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number RES-000 challed MD PhD March 25, 2006 loun, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Schoenhard MDPLD, Johns Hopkins Hospital, Tower 110, Doctors Lounge, 600 NWolfest, Bullimore MD ZIZB7 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

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	/Medic Examir		Vernon B. McI  4a. Facility Name (If not institution, g.			4b Cin	/. Town or	Location of D	03	2 1	County of Dea	0 4.95 FM
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Maryland	should od Me mark matic	2	Vernon H. McD  19a. Informant's Name/Relationship		19b Ma	iling Addres	s (Street a	Ila A	A. Tali	afer	r Town State	Zip Code 1 2 3 7
	s 1 and 2 should be filed within 72 hours efter death with the Marylar of Heelth and Mental Hyglene. Item 27 is marked other then "natural", or iteme 23s or 28s-1 ehow other traumatic event, the Medical Examinar must be notified at	r i	Frances McDani									dale, MD
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Baltimore,	permit. Pages 'Depertment of Himportant: if ite eny injury or ot once.		21. Signature of Funeral Service Lice	ensee		22. Name a	and Address	s of Facility E	Bradley	-Ash	ton Fu	neral Home
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P.O. Box 687	t the death certifica by the ettending ph ached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the birth 4 Pregnant at 9 Unknown	2 Fetal death time of death	3 □Ectopic p 5 □ Other (s	pecify)			-	23d. Date of del Month	ivery Day Year
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Σ	or Al after of Direction by	art =	4 Homicide determine		ry - At home, farm, . (Specify)	street, facto	ry, office		28f. Location City or	(Street ar Town, State	nd Number or Ru e)	ural Route Number,
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	1.+1	1	30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print)	20	0.	ζ ,		2 ()	
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Funeral				yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplac	e (State or Foreign
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Baltimore, Maryland permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if them 27 te marked oth eny injury or other traumatic event page.	П	21. Signature of Funeral Service Lice	11366			MI	lller-Di			
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Hospita 24 hours Funeral	edicai		miner: On the basis of exa and manner stated.							
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in		30. Name and address of person who	completed cause of death	(Item 23a) /T		7254		1 (	0	<u></u>
3						property and a second	. / 1 / 1			
	tate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	JKIVE IUW	SON MAR	Y L. (AVI.)	<u> </u>		
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	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. d other than "natural", or lams 23a or 28a-f show avant. The Medical Evariance was the routified at	Funeral	2005 Cedar Circle	12. Was Decedent Ever in	IIS 13	21228 Was Decedent of I	Hispanic Origin? (S		USA 14. Race - Amer	ican Indian
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=	ding Physician: The law n. Atter this certificate has E funeral director, page 2 s	o Be	examiner?	Hospital: 1 Inpatient 2		Ott	har	ath (Check only one)	2 500	7.1
5	Physical di	$\vdash$	1 Yes 25 No		ER/Outpatie	nt 3LI DOA	4   Nursing F	fome 5 Residence		ary)
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2	tand leath tor: the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					001 1		10
>	or At fter of irac n by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	nome, farm, st cify)	reet, factory, office		28f. Location (Stree City or Town, S		rai Houle Number,
ב	ital or rate or ral or rate or ral or rate or ral or rate or rate or ral or rate or rat									
	losp t hou una	edical		sician: To the best of my k iner: On the basis of exami						
	To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edi								
	To T com	Σ	29b. Signature and tive of certifier			29c. Licen	se number	29d.	Date signed (Month	, Day, Year)
			M	MEDICAL	DO1.70	RES	-000	MA	RCH 29	200 L
	W		30. Name a address of person who o	completed cause of death (II	em 23a) (Type	Print)		11 (1)		
	10		WENMAMID. 60	O HORTH WIN	LFT- CT	RE-ET E	BALTIMO	RT-, M	D2128	7
	Sta	ite	31. Date filed (Month Day, Year) 200	2. Registrar's Sig	ture	Al. D	0(11			
	Registr		MAK 9 I ZUU	ompleted cause of death (III	L. Marie					

			1 - For State Registrar	State of		nd / Depa		t of H	ealth a		_		006	09959
			1. Decedent's Name (First, Middle, Li	ast)							2. Date of De Month		V	3. Time of Death
31	Physici Medio!		Minnie Dorothy	Prete							March	28, <sup>Day</sup>	2006 Year	5:30 A. <sup>M</sup>
	/weuk Examir		4a. Facility Name (If not institution, gr		ber)		4b. City,	Town, or	Location of				County of Death	
			Stella Maris					noniu				H	Baltimo:	re
₹Ft	uneral			Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs.	last birthday)	If Unde Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	iy, Year)	9. Birth Coi	nplace (State or Foreign untry)
Di	rector		215-05-0144	TO W ZOOT	92	Yrs.					Oct.31	, 191	l3 Mar	yland
and	A m		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
Mary	i i	ō	Maryland Howard	4	E1	licott	City	7						1 ☐ Yes 2 🛣 No
the	7.28a	rec	10e. Street and Number	*				Code				10g. Citiz	en of What Co	untry?
with	38 o	Funeral Director	10285 Wetherburn	Road			2	042				USA		
deatl	E B	Jere	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.			spanic Orig	gin? (Spec	offy Yes or No Rican, etc.)		4. Race - Ame	
after	or te		1 Never Married 2 Married	1 Tes 2	No Z		ii res, spe 1 □ Yes			, rueno n	noan, etc.)		Black, White Specify: Whi	
Supplier		d by	3 XWidowed 4 ☐ Divorced	Year or Dai	es:									
22 12	nati	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Dece (Give	kind of wo	rk done di	uring most	of workin	g	16b. Kin	d of Business/I	ndustry
A High	ne Ma	E D	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT		'			C16	thing '	Industry
filed will Hygien	E H		17. Father's Name (First, Middle, Las	:t)		Seam	stre		18. Mother	r's Name	(First, Middle			Industry
VIATION Fuld be file Mental H)	o pes	o Be	Salvatore Guarne								na DiA			
shoul MA	mari	2	19a. Informant's Name/Relationship			19b. Mailir	ng Addres	(Street a	nd Numbe	r or Rural	Route Numb	er, City or	Town, State, Z	ip Code)
ad 2 alta	Important: If item 27 ie marked other then "naturel", or iteme 23s or 28s-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.		Ralph J. Prete	Son	ı	10285	Wetl	ıerbu	rn Ro	oad;	Ellico	tt Ci	ity, MD	21042
1	othe		20a. Method of Disposition		20b. i	Place of Dispo	sition (Na	me of other place	e) [	Da	ate	20c. Loc	cation - City or	Town, State
Page Tent of	nt: If Iry or		1 ☐ Burial 2 X Cremation 3 4 ☐ Donatjon 5 ☐ Other (Spec			ro Cre	mato	cy	3/					, Maryland
Dallillion Dermit. Pages Department of	Importa eny inju once.		21. Signature of Funeral Service Little	ense		22	2. Name a	nd Address	s of Facility	Ster	ling A	shtor	Schwa	b Witzke
<b>a</b> & &	E # 8		LUBICAZ	70	>~		30 E	lmond	son A	lvenu	e: Cat	onsvi	ille, M	D 21228
			23a. Part 1. Enter the disease for con shock, or heart failure. List only	mplications that ca y one cause on ea	used the dear	th. Do not ent	er the mod	de of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
Phy:	sician		Immediate Cause (Final disease or condition			DEMEN								Onset and Death
	edical miner		resulting in death)		r as a consec									
EXA	mmer		Sequentially list conditions,	b										
/ %	sit	lner	Sequentially list conditions, It as the sequence of the cause. Enter Underlying Cause (Disease or injury that initiated events	Diffe to fu	ras a conse.	friends or):								
be executed	and Il-trar	Examin	that initiated events resulting in death) Last	c. Due to (a	r as a consec	quence of):								
6 be ex	been signed by the attending physicien and should be detached for use as the burial-transit	calE												
ificate	phys	_		d										
ath certi	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			<b>-</b>					2:	3d. Date of deli	very
death o	d for	<u>c</u>	in the past 12 months? 1 ☐ Yes 2 🗶 No	4□Pregna	th 2 ☐ Feta nt at time of c		⊒Ectopic p ] Other (s;						Month	Day Year
The law requires that the death certifica	by the	Physician/Med	9 Unknown	9□ Unknov	vn									
s tha	gned se de	by P	Part II. Dther significent conditions	contributing to dea	ath but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?
w requires	en si										10	Yes 2	No 3∏Pro	obably 4XJUnknown
n w	as be 2 sh	ple									24a. Was		24b. Were au	topsy findings available completion of cause of
r å	ate h page	Completed									perfo	ormed? 2 <b>X</b> No	death?	
Oi Vital	: After this certificate has by funeral director, page 2 s	Be (	25. Was case referred to medical examiner?					1.5.		of Death	(Check only o	one)		
Phyei	this c	2	1 ☐ Yes 2 ▼No	-		ER/Outpatier			4   Nul				Cother (Spec	HOSPICE
ing F	After	o	27. Manner of Death 1 X Natural 5 ☐ Pending		, Day Year)	28b. Time o Injury		28c. Injury Work	?		8d. Describe	how injury	occurred	
Attending r death.	the t	cat	2 Accident investigati 3 Suicide 6 Could not	be One Blees	of Injuny - At h	iome, farm, sti	M factor		/es 2□N		8f Location (	Street and	Number or Pu	ral Route Number,
lor Ail	Direct in by	Certification:	4 Homicide determine	d buildin	g, etc. (Speci	<i>fy)</i>	reer, raccor	y, onice		-	City or To			7ai i lobie i valiloei,
To the Hospital or within 24 hours afte	To the Funeral Director: A completely filled in by the fu	S S	21th Cartifier 1X Cartifying F	Physician: To the b	est of my kn	owledge dent	h occuma	at the to-	e, data an	d plane ni	nd due to the	causals)	and marrier as	statud.
• Ho:	e Fuu letely	edical	(Check only 2 Medical Exa	aminer: On the ba	sis of examina	ation and/or in	vestigation	n, in my op	inion, deat	th occurre	d at the time,	date and	place, and due	to the cause(s)
To th within	To th	Me	29b. Signature and title of certifier				29	c. License				29d. Date	signed (Monti	n, Day, Year)
	•		1/2					Dy.	372	5			3/28/0	16
r	) ,		30. Name and address of person who	o completed cause	of death (Ite	m 23a) (Type,	Print)			,		•		
0	~		DR. TARIQ MAHMO			EY VAL	LEY R	D. 7	LIMON	IUM,	MD 210	93		
* 1		ate	31. Date filed (Month, Day, Year)	34 Re	gistrar's Sign	ature	all D							
	Regist	rar	MAR 3 1 2	JUB JOSE	De con	- Allen	-							

5:30 a.m.

MARCH 28, 2006

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3. Time of Death

8:05 A M

Reg. No.

Day

2006

30,

2. Date of Death

Month

March

**Physician** /Medical Examiner

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the a 90 Physicien: or Attending death. filled in by

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth
(Month, Day, Year)
July 12, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sax 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F 1946 Florida 59 Director 217-52-4746 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle ?7 is marked other than "natural", or itame 23a or 28a-f ebov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10804 Bellehaven Boulevard 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after thygiene.
Hygiene. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Lockheed Martin Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance Manager Aeronautics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 is marked out Be ၉ James Robert Parkinson Faye Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 10804 Bellehaven Boulevard, Damascus, Maryland Mary Ann Parkinson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ò 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Department of important: If eny injury or pace. Metropolitan Crematorium 3/31/06 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Libensee 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland tover 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Enntin AC4710 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MYOCAN, Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Monknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHOUPSEROL EMIA 24a. Was an After this certificete has funeral director, page 2 s 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Mannef of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter deat To the Funerel Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the wasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054139 2066 70. 11.0. MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 9901 Medical Center Drive, Duc Rockville, Maryland 20850

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

			Flease	State of Many				•	_			
			1 _ State	State of Mary		ertificate of			ZHUb	09961		
41		-	Registrar	041		)	Dealii	2. Date of Death	J. Nd.	2 Fire of Doort		
	Physici /Medio		1. Decedent's Name (First, Middle, La	er C	F	ayn.	9	Month MARCH	Day Year 28 2006	3. Time of Death		
1	Examir		4a. Facility Name (If not institution, giv		206		r Location of Death		4c. County of Deat			
		33.00							70 / 7	f (Same as 5 as in a		
	Funeral Director	ý	5. Social Security Number 6. S 251-10-5951	M 2□F	Yrs. last birthday	Months Days	Hours Min.	8. Date of Birth (Month, Day, )	(ear) Siru	nplace (State or Foreign untry) th Caroling		
	D .		Usual Residence of Decedent		1							
	hours after death with the Maryland tural, or Iteme 23a or 28a-f show at Examinatination must be motified at	ō	10a, State 10b. County	J/A	c. City, Town or I	Baltin	mare)			10d. Inside City Limits 1 Yes 2 □ No		
	or 28a	irect	10e. Street and Number		2,	10f. Zip Code	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	g. Citizen of What Co	untry?		
	eth wil	Funeral Director	2000	nner k	d.	21	216		03	<i>A</i>		
	9 2	P P	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	<ul> <li>Was Decedent of H</li> <li>If Yes, specify Cuba</li> </ul>	lispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
8	orl		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:						Specify:	Jan D		
Š	iral'.	d b	3 Widowed 4 □ Divorced	Year or Dates:					L	racro		
3-003e		ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup re kind of work done	durina most of work	ing 16	6b. Kind of Business/	Industry		
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and	tal H d ot		17. Father's Name (First, Middle, Last	Oc. a			2 .	First, Middle, Ma	$\circ$			
_	Men Men arke	မ	Clinton	rayne			Lillia	in t	ayne			
ary	and and		19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	iling Address (Street	and Number or Rur	al Route Number, (	City or Town, State, 2	Tip Code)		
≥	alth 27		Darryl Pay	ne - 200	1 380	3 Bonn	ner Icd.	Balto	0, md, 2	21216		
Baltimore,	t Healt trem 2		20a. Method of Disposition		Ob. Place of Disp	position (Name of tematogy or other place		Date 20	c. Location - City or	Town, State		
ဋ	2°= =		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	meta	//	ton 4-3	5-06 (	Co tom Co	ib md.		
ቜ			21. Signature of Funeral Service Lice		110170				the	Pass		
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			23a. Part Emer the disease, ir com shock, ir heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between		
	Physician		Immedia Cause (Final disease or condition			UMONI			10	Onset and Death		
<b>)</b> (1)	/Medical		resulting in death)	Due to (or as a co		0				al DHIS.		
	Examiner					INDV F	PIDDACIO	,		21 DAYS.		
		E .	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury							XI DHYS.		
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_	te be executed ysician and ne burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as a cor	nsequence of):							
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9	leath certificate ettending phy: ifor use as the	Xe	IF FEMALE:									
ROX	endi endi	5	23b. Was decedent pregnant	23c. If yes, outcome of pr		☐Ectopic pregnancy	,		23d. Date of del	•		
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	and and and and and and and and and and	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						cco use contribute to	the cause of death?		
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Division of	atter Direction by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)	street, factory, office		City or Town,		rai noute Number,		
_	spite ours serel		29a. Certifier 1 Certifying Pl	nysician: To the best of my	knowledge des	ath occurred at the tin	ne, date and place	and due to the carr	sa(s) and manner as	stated		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Example)	niner: On the basis of exa- and manner stated.	mination and/or	investigation, in my o	pinion, death occurr	ed at the time, date	and place, and due	to the cause(s)		
	omp	Me	29b. Signature and tille of certifier			29c. Licens	e number	290	I. Date signed (Monti	n, Day, Year)		
	~		Servace	hala MD	,	PI	9923,	1	TARCH 2	8 2006.		
•			30. Name and address of person who									
	1		SUVARCHALA	KOMPELLA	MO !	ST. AGNE	S HOSPI	TAL, B	ALTIMOR	E, MO		
2 4	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's S	Signature	will !						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day March 21, 2006 11:03 A M Margie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton
If Under 1 Year
Months Days <u>Southern Maryland Hospital</u> Prince George's 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Hours Director May 25, 1919 500-24-1670 86 AL Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director NONE Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3378 Highwood Drive SE 20020 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Item 27 Ie marked other that eny injury or other traumatic event, Insu 2002. 10 General Motors Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Pryor Lazette Lang 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie Singleton/Niece 5503 Kershaw St., Forestville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Strawbridge Cemetery 4/1/06 4 □ Domation 5 □ Other (Specify) Ethelsville, AL 21. Sign ure of Funeral Service Licenses 22. Name and Address of Facility Lavendar Funeral Service Highway 17 South, Aliceville, AL men omno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) or our festinal **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examine To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 X No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 1 Inpatient 2 TEH/Outpatient 3□ DOA After the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation s after dec. 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SOICONICWO, MD 00059314 03.23.2006 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)
SYLV 657 GR OLLON KWD, 6192 UNON NTLL RUISTE 50 + CXUN 17TH, 17TU 20145 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.							5 09963		
	Dhuaiai		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death		
	Physicia /Medic		Martha		Pr	ice	MARCH	25,	2006	5:54PM		
	Examin		4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, or			4c. Cour	ity of Death			
			Sinai Hospital		Baltime							
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	y, Year)	Cour			
	Director		214-40-1813	63			09 15	42	I M	ID		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation				1	0d. Inside City Limits		
	fanyl	ō		5 11 1						1 XYes 2 ☐ No		
	r 28a-f ehow	Funeral Director	MD NA 10e, Street and Number	Baltim	10f. Zip Code			10g. Citizen o	of What Cour	ntry?		
	with Se or		5005 Palmer Ave		2	1215		IJ	.S.A.			
	death me 2;	era	11 Marital Status 12. Was Dec	edent Ever in U.S. 13	. Was Decedent of His If Yes, specify Cubar		cify Yes or No		ace - Americ	an Indian,		
Maryland 21215-0036	72 hours after death with the Maryland nature!', or Iteme 23a or 28s-1 show disal Examiner must be notified at	by Fur	Armed F  1 □ Never Married 2√2 Married 1 □ Yes  3 □ Widowed 4 □ Divorced Fyear or I	N XXNO	1 ☐ Yes 2 ☑ No	Specify:	Alcan, etc.)	Spec	lack, White,	ack		
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21	should be filed with and Mental Hygiene marked other the imatic event, inc.	Š	12th grade na		Housewi				ome			
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Baltimore,	permit. Pages 1 Department of H Important: If its eny injury or ott		21. Signature of Funeral Service Licensee		22. Name and Address March F/	H West						
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			shock, or heart failure. List only one cause on each line.									
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Division of Vital Records,	sician: T certificet rector, pa	0	25. Was case referred to medical			26. Place of Death						
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	(0		30. Name and address of person who completed can OLUSEGUN LAWOY!	ise of death (Item 23a) (Typ	e, Print)	OUDT &	CAR H:	ROE RE	AKMA	1157WW MI		
	4			Registrar's Signature	10 -17	41/1 6	~ · · · · · · · · ·	, (4	110711	,, ,,,,		
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State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ERNEST K. PULSIFER MARCH 29, 2006 11:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 209 2ND AVE., S.E. CLEN BURNTE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min OCTOBER 15,1937 WEST VIRGINIA Vrs 68 217-34-6286 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or items 23a or 28a-f ehov Exeminer roust be notified at 1 ☐ Yes 2 X No MARYLAND ANNE ARUNDEL GLEN BURNIE Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code death with 209 2ND AVE., S.E. 21061 UNITED STATES by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item eny Injury or other traumatic event, Ite Modical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: KORIA Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL WRITER STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES CAMERON PULSIFER, SR. ELIZABETH MCCLUNG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JANET PULSIFER / WIFE 209 SECOND AVE., S.E., GLEN BURNIE, MD 21061 Date 3, 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State APRIL cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEM. PARK 2006 GLEN BURNIE, MARYLAND 4 🗆 Do 5 ☐ Other (Specify) Service 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** adu mo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performed 2 No 2 No 1 Yes 1 Yes to the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check only or Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA this Director: After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 AMatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di cumpletely filled in 1 in the last of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier (Check only one) 29b. Signature and Me bi certifier 29c. License number 29d. Date signed (Month, Day, Year) me am addres of person competed cause of death (Item 23a) (Type, Print) 30 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 9.11.12.15.16-20.22 8036 6-9-06 yt

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 1940 **Physician** 26 2006 RANDOLPH MNDA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY GENERAL HOSPITAL DLNEY MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** 1 ☐ M 2 🔯 F 60 California 08-17-1945 Director 570-60-7331 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow s 1 and 2 should be filed within 72 hours after death with the Marylas of Heath and Mental Hygiene.
Item 27 is marked other then "naturel", or Items 23a or 28s-1 ehow other traumatic event, it a Medical Exam har must be to Miled at 1 XYes 2 No Silver Spring MD Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3544 Chiswick Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 200 Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luella May Savage (Anderson) Harold Gossett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3544 Chiswick Court Silver Spring MD 20906 David L. Randolph/Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Crematory 03-29-2006 ō = 5 1 ☐ Burial 2XXX remation 3 ☐ Removal from State Beltsville, MD 4 □ Donation 5 □ Other (Specify) permit 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 Ma1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZWEEKS PNEUMONIA **Physician** /Medical Due to (or as a consequence of) > 6 MONTHS Examiner LATERAL SCLEROSIS AMYOTROPHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 76 MONTHS or Attending Physician: The law requires that the death certificate be executed PESTRICTIVE LUNG DISEASE Exam attending physician and burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death signed by the all id be detached for Ö 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗀 No this certificate 1 ☐ Yes 2 No 1 Yes ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospitei within 24 hours a To the Funeral C 🔀 Cartifying Physician: To the best of my knowledge, death unremed at the time, date and place, and due to the causels) and manner as stated 76e Conflor Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies D62656 MARCH 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIOLPRINCE PHILIP DRIVE DLNEY MARILAND 20832 SONIA HOLMES, M.D 32. Agistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 3 1 2006

State of Maryland / Department of Health and Mental Hygiene U U b For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 3:15 AM M March 29, 2006 Frances Eileen Rosemary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab. Center Montgomery Burtonsville 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 ☐ M 2 🖾 F 86 Yrs. Director 06/20/1919 456-24-0079 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow r then "neturel", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20901-IISA 9506 Biltmore Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Caucasian Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Clerical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be filment of Health and Mental Hisnt: If item 27 is marked ott Julius Osborne Downey Georgia Mae Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Peggy Weaver Kay/Daughter 9506 Biltmore Dr. Silver Spring, MD 20901-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Mar 31 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2006 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services
933 Gist Ave. Silver Spring, Maryland 20910-2 m2135 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Cerebro Vascular Accident Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physicien and for use es the burial-transit or Attending Physicien: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2**X**Mo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ို 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 K Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 03-29-2006 D25348 lamarh Marriee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Goldmark 15020 Shady Grove Rd. Rockville MD 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

2006

	196		1- For Amend Item			Ce	runca	10 01	Dealli			g		7 7 7 7	
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Eudoro Iris Roberts								. Date of Death Month	Day	Year	3. Time of D	
	/Med Exam									Death	03	4c. Cou	2006 nty of Death Montgo		
	Funera Director		5. Social Security Number 6. 579-88-8047	Sex 7 1 □ M 21X F	Age (In yrs	last birthday) Yrs.	Months Days Hours Min.			Min. 8	8. Date of Birth (Month, Day, Year) 02-17-1911		9. Birthplace (State or Foreig Country) West Indies		coreigr es
	and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d. tnside City Limits				
	ith the Marylar or 28e-f ehow	ţō	MD Montgomery Takoma Park						ark					1 ⊠Yes 2	
	ith the	Oirec	10e. Street and Number				10f. Z	ip Code			10g. Citizen of What Country?				
	• 23a	rail	6701 Allegheny A			10	20912					USA			
960	be filed within 72 hours after death with the Maryland hal Hyglene. Id other then "naturel", or Iteme 23a or 28e-f show event, the Madical Examiner must be notified at	by Funeral Director	(Specify only highest grade completed) ( Elementary/Secondary (0-12) College (1-4or 5+)				3. Was Decedent of Hispanic Origin? (Specify of the Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes XXNo Specify:    Concedent's Usual Occupation wire kind of work done during most of working and No NOT use retired.				ly Yes or No- can, etc.)	y Yes or No- an, etc.) 14. Race - Ame Black, Whi Specify: B1		etc.	
Monitord 2121E 002E	thin 72 ho	Completed				(Give									
5	it, the		12 Homemaker									Own Home			
Suc ly	S E E	To Be	17. Father's Name (First, Middle, Last)  Unobtainable  18. Mother's Name (Unobtainable)  Unobtainable						obtai						
2	i C, Mal y ic s 1 and 2 should f Health and Mer itsm 27 is marke other treumatic		19a. Informant's Name/Relationship Enid L. Alleyne/								Route Number, a Park			Code)	
9	Pages 1 Dent of He ont: If Iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from St		Place of Dispo cemetery, cren	sition (Na natory or	ame of other plac	· i	Dat	- 8	Oc. Locatio	n - City or To	own, State	
294	Destriction of the permit. Pages 1 and 2 Depertment of Health 2 Importent: If Itsm 27 is any Injury or other trepage.		4 Donation 5 Other (Specify) Gate of Heaven 04/01/20 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility												)
å	Depermit. Depermit imports any inject.		V (21 11 1 (1)11	mam	M003	82	Rapp	Fune	ral &	Crem	ation S Spring	ervic	e 1910		
5000 2000 S	Attending Physician: The law requires that the death certificate be executed in death.  The death.  Sector: After this certificate has been signed by the ettending physicien end in property the tuneral director, page 2 should be deteched for use as the burial-transit and in property.	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to lor	e ps as a consec as a consec as a consec	thmia	`							Onset and De	
65(2)	that the death certifica ed by the ettending ph deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown	23c. ff yes, outco 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Feta It at time of o	al déath 3 🗌	Ectopic p Other (s	oregnancy pecify)	10.0			4	23d. Date of delivery Month Day Year		
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ROBERTS	The law requirements that has been single 2 should it	Completed	Stroke							_	24a. Was an autopsy performe	d	death?	psy findings avantetion of caus	ailabte se of
$\frac{2}{\sqrt{2}}$	detifice rector, p	BeC	25. Was case referred to medical examiner?		-				26. Place of	of Death (C	-	No	1 🗆 Yes	2 L No	
	Physic this ce	유	1 ☐ Yes 2 No	Hospitat: 1 ☐ fnp		ER/Outpatien			4 U Nurs	ing Home	5 🗌 Residen	ce 6 🗆 C	ther (Specif	r)	
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UDORA	- 5 = -	Certification;	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined wilding, etc. (Specify)  M 1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								Location (Stre City or Town,	et and Nui State)	mber or Rura	il Route Numbe	<i>f</i> ,
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	To the To the Comp	×	29b. Signature and title of certitier	of Calaci	Phys	i ci qua		c. License	number	6	Ä	Date sign	25 <sup>Month</sup>	006 <sup>Year)</sup>	
	2		30. Name of address of person who completed cau e of death (Item 23a) (Type, Print)												
	(/	II - 8	Barton V	N/ 1	1910	1.MD								1D 2081	

			For State Registrar	State of Ma	aryland	•	rtment of H		Mental Hy	giene	09969
	Physici	an	1. Decedent's Name (First, Middle, Last)	-	RI	)ETH			2. Date of Dea Month	Day Yea	
	/Medic	al	ROBERT  4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o	r Location of De	MARKel ath	20, 200k	
	LXamiii	C1	NORTHWES	T HO	PITAL				USTOWN		ALTIMAR
	Funeral Director		5. Social Security Number 6. Sex 219–18–6930	7. Ag	e (In yrs. Ia 82	st birthday) Yrs.	Months Days	Hours M	n. 8. Date of Birt (Month, Day March	13,1924 Ma	Birthplace (State or Foreign Country) aryLand
	7		Usual Residence of Decedent						11011011		
	Aaryiar Febow	ō	10a. State 10b. County			Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 288-	Director	Maryland Baltimore  10e. Street and Number	2	Dali	imore	10f. Zip Code			10g. Citizen of What	Country?
	ath with		3638 Sussex Road				212			USA	
920	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow sayl injury or other treumatic event, the Medical Examinar must be multilled at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	H	Vas Decedent of H Yes, specify Cub ☐ Yes 2 2 No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, W	mencan Indian, Thite, etc. White
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d 2	e filed ai Hygi other vent,	Be C	17. Father's Name (First, Middle, Last)			DCII	Linpitoy	18. Mother's N	lame (First, Middle,	Maiden Surname)	<u>,                                      </u>
ylaı	ould b	To	William Henry Roe						re Mallabi		
Maryland 21215-0036	od 2 sh Ith and 27 is m		19a. Informant's Name/Relationship (Typ. Pauline Roeth W:	ife						er, City or Town, State Maryland	
ore,	of Hea		20a. Method of Disposition  1  Burial 2 X Cremation 3 Re		20b. Pla	ace of Dispos	sition (Name of patory or other pla		Date	20c. Location - City	
Baltimore,	ment tant: if		4 □Donation 5 □ Other (Specify)		Met	ro Cre	matory				le, Maryland
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	Physician		23a. Part1. Enter the disease or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition						ULAN		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):		<del>.</del>			
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):					
8760,	ate be executed hysicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):					
9	tificate ig phys as the	ledic	d								
О. Вох	at the death certificate be executed by the attending physicien and trached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	/		23d. Date of Month	delivery Day Year
<u>α</u>	gned be de	ρ	Part II. Other significant conditions con	tributing to death b	ut not resul	lting in the ur	derlying cause gn	en in Part I.			e to the cause of death?  Probably 4 (Wunknown
of Vital Records,	The law requir ete hes been si page 2 should	Completed								rmed/ death	autopsy findings available to completion of cause of
ita		BeC	25. Was case referred to medical examiner?			,		26. Place of D	1 ☐ Yes Death (Check only o	2 <b>V</b> No 1 □ 1	∕es 2 √ No
of <	this al di	၉	1 ☐ Yes 2 ☑ No H	ospital:		R/Outpatien	3 DOA			dence 6 Other (S	(pecify)
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	Horar Hos	edical (	29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	ician: To the best er: On the basis of and manner st	f examinati	rledge, death on and/or inv	occurred at the ti restigation, in my o	me, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the I	×	29b. Signature and title of certifier	0	1.1	14%	29c. Licens	e number		29d. Date signed (M	
,	181		30. Name and address of person who co	104	NY /	<b>Ч</b> () 23a) (Туре, і	D D	4544	)	11/10/41 29	, 2006
	(O'' '		MICHAEL ROTHYP	5401	00	D COV	ET ROYS	RANDA	LSTOMU	MARY LAW	21133
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 200	32 Registr	ar s signati	Ace	all s				

Larry Rice 06-02166 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Unpend item#23a 1 - For Registrar	,27 perME State of	C854 Marylar	17/06 TT Ger Ce	artmeni rtificate	t of H	ealth a	and M	lental Hy	giene Reg. No.	006	099	170
		Decedent's Name (First, Middle, La	st)							2. Date of De	eath		3. Time o	f Death
Physicia		Larry Rice								Month March	Day 28	3 200		
/Medic Examin		4a. Facility Name (If not institution, give	e street and num	ber)		4b. City,	Town, or	Location of	of Death	1202 011		County of De		
aaiiiii		Sinai Hospital				В	alti	more						
Funeral		Social Security Number 6.5		. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. B	rthplace (State	or Foreign
Director		210-00-0116	IM 2□F	42	Yrs.	Months	Days	nours	MIII.	12/25/	1963		country) th Caro	lina
D >		Usuel Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Lo	antina.							T404 ti4- 0	5 . 8 t — te-
anyla eho	ក				Baltimo								10d. Inside C	2 □ No
the N	ect	Maryland  10e. Street and Number			Dartine	10f. Zip	Codo				10= Citi	en of What C		
with the or	by Funeral Director									i			ountry :	
leath ns 23	era	3829 Beehler Ave	12. Was Deced	lent Ever in t	J.S. 13.		L215 lent of Hi	ispanic Ori	igin? (So	acify Yes or N	U.S		erican Indian,	
fler	표	1 Never Married 2 Married	Armed Ford	es? 2.5⊽No		_				ecify Yes or N Rican, etc.)		Black, Wh		
Surs a		3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2	2∏ No	Specify:				Specify:	Black	
72 hc	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of work	ina	16b. Kir	nd of Busines	s/Industry	
ithin Mark	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	e retired	)	i oi nom	,,,,	Car	rier T	ranspor	t
led w	ပိ		1		Truci	C DI IV	/ei	40.14.4						
d be file	Be	17. Father's Name (First, Middle, Last	)							e (First, Middle	, Maiden	Sumame)		
y 10 nould marks marks	은	Willie Rice  19a. Informant's Name/Relationship	Time Deint		105 14-16		(0)1		en F		0:	<b>-</b>	7: 0 ! )	
ine, intally lated Z 1Z 13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the Alth and Mental Hygiene. other traumatic event, the Macical Examinar must be notified at		Carolyn Jordan /								al Route Numb ltimore				9
Heal The Sther	1	20a. Method of Disposition	715001	20b.	Place of Dispo	sition (Nam	ne of	T	13.5	Date			r Town, State	
Pages nent of l		1 ☐ Burial 2 🕅 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		tate	cemetery, creating tro Cre	matory or of	ther plac		/ <sub>1</sub> / 03	/2006			Maryla	nd
		21. Signature of Funeral Service Lice		1					-				•	
permit. Departition of the permit of the per													F/H, P yland 2	
		23a. Part1. Enter the disease, or con	plications that ca	sed the dea								e, mar	Approxima	te
Physician		shock, or heart failure. List only tmmediate Cause (Final			- C			п					Interval Be Onset and	tween Death
/Medical		disease or condition resulting in death)		r as a conse	of syste	ande lu	pus,	Erytha	amatos	SUS				
Examiner		Comment of the first area distinguished	b											
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ate be execu		tosuming in death) cast	Due to (c	r as a conse	quence of):									
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w requires that the death certificate share the death certificate been signed by the attending phannel be detached for use as the strong of the detached for use as the detach	/Me	IF FEMALE:	23c. If yes, outc	ome of orego	ancy									
eath attentor for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fet	al death 3	☐Ectopic pro☐Other (sp					2	3d. Date of do Month		Year
She the contract of the contra	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		<b>J</b>	_ Cillel (sp	ociiy)							
that the detail		Part II. Other significant conditions	contributing to dea	ath but not re	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco u	se contribute	to the cause of	death?
w requires to been signed should be	d by									10	Yes 2	]No 3∏F	robably 4 🖄	Unknown
s bee	Completed									24a. Was	s an	24b. Were a	utopsy findings	available
The ta	E O										ormed?	prior to death?	completion of	ause of
Of VICAL DEC Physician: The lav this certificete has ral director, pege 2	0	25. Was case referred to medical						26. Place	of Deatl	Check only	2 □ No	)ACL Y 6	s 2 No	
ysici ysici is ce direc	To B	examiner? 1 <b>∑X</b> es 2 ☐ No	Hospital: 1   In	patient 2	ER/Outpatie	nt 3 DO	A Othe	200		me 5□Res	- 10	Other (Sp	ecify)	
To Phy Phy Control of the control of	) 1	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time o	f 2	8c. Injury Work			28d. Describe				
Attending or death.	atle	2 Accident investigation	n			М		Yes 2□	No					
or Att	ertification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place	of Injury - At I g, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory	, office				(Street and wn, State)		Rural Route Nur	nber,
urs a	O		1/4											
Hos 24 ho Fun stely f	edical	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa one)	hysician: To the i miner: On the bar and mann	sis of examin	owledge, deat ation and/or in	h occurred a vestigation,	at the tim , in my or	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time	cause(s) , date and	and manner a place, and du	is stated. ie to the cause(	s)
To the Hospitel or Attending Physician: The law requires that the death certificate be executivity at hours after death.  To the Funeral after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, pege 2 should be detached for use as the buriat-trained.	Med	29b. Signature and title of certifier	unia mamm			290	. License	number			29d. Date	signed (Moi	nth, Day, Year)	
F 5 F 0		DINO D	,				C	CME				h, 29.		
1		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Tvpe.	Print)						,,		
0		A	OIMP	,		•	1 Pe	nn St	treet	Balt	imore	e. Mary	1and 21	.201
Sta	-	31. Date filed (Month, Day, Year)	1 .4	strar's Sign	nature							,		
Registr	ar	MAR 3 1	2006	Bester	A. A.	book	1							

L	Exa	amino
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 34 hours after death.	minui. Exp. Housa and useau. Obsertive and the serviticate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
Division of Vital	To the Hospital or Attanding Physician:	To the Funeral Director: After this certification completely filled in by the funeral director, p

DHMH 17 Rev 1/2001

٠			Pleas 1 - State Registrar	State of M	aryland / Depa		lealth and I	Mental Hygi	_	09971
	Physici /Medic		Decedent's Name (First, Middle, Damon	Last) Reuyon	Ratcli	ff		2. Date of Death Month March	Day Yea 24, 2006	3. Time of Death 7:30 AM
	Examir		4a. Facility Name (If not institution,	-			r Location of Death	ו	4c. County of De	
			Anne Arundel Me			Annapo		O Data of Diat	Anne A	
	Funeral Director		5. Social Security Number 587-15-8359  Usual Residence of Decedent	6. Sex 7. Ag 1⊠ M 2□ F	e (In yrs. last birthday)  Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV. 6,	Year) 1966	Birthplace (State or Foreign Country) NY
	Maryland -f show	tor	10a. State 10b. County	rundell	10c. City, Town or Lo					10d. Inside City Limits 1. Yes 2 □ No
	th the or 28s	Director	10e. Street and Number		1	10f. Zip Code	·	10	g. Citizen of What	Country?
	23a c	a	221 S. Cherry G	rove Avenue		21401			USA	
5-0036	in 72 hours after death with the Maryland n'natural; or Itams 23a or 28a-f show lodical Existin et mai Le neillied at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ad 1 ☐ Yes 2 점 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Al Black, W Specify: I	
0-CLZ	hin 72 ho e. an "natur Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	rking	6b. Kind of Busine	ss/Industry
7	e filed within Il Hygiene. other than " vent, I' e Med	Соп	12	1		look			Restaura	int
ב ב	be d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, L	ast)				ne (First, Middle, M	aiden Sumame)	
Maryland	should be nd Mental markad c	ဥ	Fred Carter  19a. Informant's Name/Relationsh	in (Tuna Print)	10h Maili	na Address (Stroot		Ratcliff  ra/Route Number,	City or Tourn State	Zin Codo)
<u>E</u>	id 2 s lth an 27 is i		Joe L. Ratclif			-		, Accokeel	-	0607
ē,	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		20a. Method of Disposition		20b. Place of Dispo				0c. Location - City	
altimore,	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		Western Reserve			2006	truthers	Obto
Balti	perrit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	icensee	22	2. Name and Addre	ss of Facility L.		-Phillips	-Holden FH
	Physician /Medical		23a. Pa/11 Inter the disease, or slock, ir heart failure. List of Immediate Lause (Final disease or condition resulting in death)	a. 10	ule M	ter the mode of dyin	ng, such as cardiac	r respiratory arres	cto-	Approximate Interval Between Onset and Death
68/60,	be executed ician and purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):  a consequence of):  a consequence of):	<u>Qu</u>	my d	use es	<u>.                                    </u>	
C. BOX	death certif e attending od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc: □ Other (specify) _	у		23d. Date of Month	delivery Day Year
ds, P	luires than signed I	by	Part II. Other significant condition	o server	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	. /	to the cause of death?  Probably 4Unknown
Vital Records,	The taw requires that the cate has been signed by the page 2 should be detache	Completed	3 Hyperte	bron,	) in			24a. Was an autopsy perform	ed? prior to death	autopsy findings available to completion of cause of ?
ā	G CT	a	25. Was case referred to medical				26. Place of Dea	1 Yes 29 ath (Check only one		65 2 140
	hysic nis ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 20 ER/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	ome 5 ☐ Resider	nce 6 Other (S	pecify)
ion or	anding Physician: ath. vr: After this certific ne funeral director,		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y Year) 28b. Time o	Wor	y at rk? Yes 2 □ No	28d. Describe how	v injury occurred	
DIVISION	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	and   28e. Place of Inj	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	he Hospi n 24 hour he Funer pletely fill	edical	29a. Certifier 11 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner st	f examination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
•	To t within To tl	W	29b. Signature and title of pertifier	J Chu	I	29c. Licens	se number	3 29	d. Date signed (Md	onth, Day, Year)
	21		30. Name and address of person w	(MO)	DOODW	day Pl	eur, R	mrs	( ( ( ) )	140/
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32 Registr	ar's Signature	well .	11			

ORIGINAL

		·	For State Registrer	State of Mary			of Health and of Death		giene Regino 0 0 6	109972
6.	Physici	an	Decedent's Name (First, Middle, La LEON	LOU	IT C	RUB	T NI	2. Date of De	Day Ye	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, gire				wn, or Location of De	- March	4c. County of E	06 3 4
	(n) +	3/4	Sinai Hospi	tal of Ba	Itimore	Bal-		City		N/A
	Funeral Director			Sex 7. Age (In 1 ☑ M 2 ☐ F	yrs. last birthday			in. 8. Date of Bir Month, Da NOV . 20	h y, Year) 1016	Birthplace (State or Foreign Country)
ala Fi			Usual Residence of Decedent	٨	09			1104.20	,1910	MD
	the Maryland r 28a-f show rolling at	-	10a. State 10b. County		c. City, Town or I					10d. Inside City Limits
	the M	Director	MD BAL  10e. Street and Number	TIMORE	BAL	TIMORE 10f. Zip Co	nde.		10g. Citizen of Wha	1 Yes 2 No
	h with	io ie	2 POMONA EAST #3	06		701. 210 00	21208	3	Tog. Onzen of Wha	USA
920	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar rust be notitled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:	r in U.S. 13	. Was Deceden If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu (No Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race - / Black, V Specify:	American Indian, White, etc. WHITE
Maryland 21215-0036	를 <b>로</b> 볼	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Giv	DO NOT use i	tone during most of	working	16b. Kind of Busin	,
d 2	be filed with tal Hygiene. Id other there went, tre	Be Co	17. Father's Name (First, Middle, Las.	")	OWITE	-11	18. Mother's I	Name (First, Middle,		IAL
/lan		To B	NATHAN		RUB:	I N	IDA			GOLDBERG
Man	2 2 3		19a. Informant's Name/Relationship	**					er, City or Town, Sta	
	Heal Heal tem 2		A. RONALD RUBIN  20a. Method of Disposition		Ob. Place of Disc	osition (Name	of T	Date - UW	20c. Location - City	or Town, State
E C	0 0		1 X Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Speci	Removal from State by)		ematory or othe 1EMORIAL	PARK 03/	30/2006	RANDAL	LSTOWN, MD
Baltimore,	permit. Pag Department Important: I eny Injury o	1	21. Signature of Funeral Service Lice	1. attle		22. Name and A	Address of Facility	OL LEVINS	SON & BROS	
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	death. Do not e	nter the mode o	f dying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	insequence of):					7_
		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	movilo					T
	acuted ind transit	Examiner	that initiated events	c						
8760,	ate be executed thysicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a co	insequence of):					
9		/Med	IF FEMALE:	220 If you guteeme of p						
.O. Box	The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregr □ Other (speci			23d. Date of Month	delivery Day Year
ords, P	w requires that been signed to should be det	ed by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying caus	se given in Part I.			te to the cause of death?  Probably 4 Donknown
Division of Vital Records,		Completed						24a. Was autop perto 1 \( \text{Yes}	rmed?/ deat	
Vit	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Other	Death Check only o		
o	g Physie this neral dir	n: To	27. Manne of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie		4 ☐ Nursin- Injury at Work?	_	dence 6 Other (	Specify)
sior	E 2 2	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigated	n	a <i>r)</i> Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Divis	Hospital or Attence 4 hours after death Funeral Director: lely filled in by the I	Certification;	3 Suicide 6 Could not to determined	building, etc. (S	ipecify)			City or Tou	vn, State)	r Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direcompletely filled in D	Medicai	one) 2 Medical Exe	hysicien: To the best of m miner: On the basis of exa and manner stated.	imination and/or i	nvestigation, in	my opinion, death o	ace, and due to the courred at the time,	date and place, and	due to the cause(s)
	5 # 5 g		29b. Signature and title of certifier	M-M	10	RE	S-000	)	March	fonth, Day, Year) 28 2006
	10		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	F Balt!	2000		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	. 1-1( 0	1 0 1111	707 2		
DH	Regist	1.00	MAR 3 1 2006	Block B	Append	U .				

DHMH 17 Rev 1/2001

Patient Known as Lean Rubin

Amend Item #12 Per FH G854 4/05/06 Jh State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per Dr., G853e08i/21d06dPheath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Vear **Physician** 230 John Randall a M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland ortal SMURL NA Date of Birth (Month, Day, Year) 10-7-21 7. Age (In yrs. last birthday Vear If Under 24 Hrs. 5. Social Security Number If Under Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 84 225-26-2232 Va. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at ¥ Yes 2 No Md. Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2319 Whittier Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes Sive Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any injury or other treumatic event, the Medicance. State of Virginia Elementary/Secondary (0-12) Colfege (1-4or 5+) Piedmont Hosp. 12th grade Housekeeping Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Randall Harry Jennie Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 2319 Whittier Avenue, Baltimore, Md. 21217 Benita Hill Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Virginia Veteran Cem. 3-24-06 Amelia, Va. 21. Signature Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Acute Tubular Necrosis as a conseque nge of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 1☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Pface of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturaf 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

Registrar

DHMH 17 Rev 1/2001

State

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene [] 19976 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30, 2006 Garland Smith 11:15 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, SEP 30) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 213-38-6882 NC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 2801 Cheswolde Road USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or Dates: 58-6 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 58 - 6116a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Mildred Allen Smith 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra K. Smith - wife 2801 Cheswolde Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State permit. Page Department of Important: if any Injury or once. ö Chesapeake Crematory 4/1/2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD Ha M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** schemic Cardiomyopathy disease or condition resulting in death) YZQ1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuguence of) Examine use as the burial-transit the attending physicien and Due to (or as a consequence of). P.O. Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) OSPI C ပ 1 ☐ Yes 2 ☐ No After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 30 2006 5830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. wo 6601 BALTIMOR MO 2124 50 31. Date filed (Month, Day, Year) State 1 2006 Registrar

SMILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09975 State of Maryland / Department of Health and Mental Hygiene | For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Schulz, Sr. March 27, 2006 Clinton John 10:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral %** M 2 ☐ F Months Days Hours Yrs. Director 215-22-2276 78 July 6, 1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford <u>Havre de Grace</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Revolution Ave. 21078 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑X es 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: ģ 3€ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 6 Truck Driver Raw Materials 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ind Mental i and Menta Edward August Schulz Freda Geraldine Horst 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 te m eny injury or other treum once. Christine Hazelton / Daughter 28636 Via Piedra, Valley Center, CA 92082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 3-29-06 Towson, Maryland 21. Signature of Funeral Service Licensee 2Macomas Funeral Home, P.A. Mussell Sty 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine use as the burial-transit Due to (or as a consequence of): nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ▷ No Director: After this certificate has in by the funeral director, page 2 1 Yes 200 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

10+1

completely

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

Muhammal 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Jokhadar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



**ORIGINAL** 

28/ E.

Main

29d. Date signed (Month, Day, Year)

St. Rising Sun, MS 21911

State Registrar DHMH 17 Rev 1/2001

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			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.		01 1110 1111	odo or dy ii r	9, 00011 00	02101200	roopiiatory c	.,,			Onset and	etween 1 Death
F	hysician /Medical		disease or condition resulting in death)	a	Seps								,		124	OUN
E	Examiner			Due to (or a	Blois	nce of):	Pa	, im	00	. 6				-	vee	lee
		0	Sequentially list conditions if any leading to immediate	b. Due to (or a	is a consequer		1	M	0 21 .	-					W. C.E	
1	Insit	Examiner	Sacus tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
	sician and Sician and Surial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	is a consequer	nce of):										
	cate be physicia the bur	dicai		d												
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ledi									-2,-3					
	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnance 2 Fetal de		Ectopic	pregnancy				1		te of delive	ry	
	ie dear the att hed for	Sicia	in the past 12 months? 1 Yes 2 No		at time of deat		Other (						Mo	onth	Day	Year
	that the di ed by the detached	hys	9 🗌 Unknown	an Ouknown												
	res tha igned be del	by F	Part II. Other significant conditions of	_	but not resulti	ng in the ur	nderlying	cause give	en in Part I.	,	23e. Did	tobacco u	se conf	tribute to th		
	been si should	Completed	C0/007 Ca	1662							1 🗆	Yes 2	No	3 Prob	ably 4	Unknown
<b>S</b> .	has be	pie									24a. Was		24b.	Were autop	osy finding	s available
	ate h page	No.										ormed? 2 ☐ No		death?	2 🗆 No	
3 .	rnysician: Inelithis certificate har	Be (	25. Was case referred to medical examiner?	,			_		26. Place	of Death	Check only	one	-			
מי אומו זוככסוקפי	nysio nis ce l dire	2	1 ☐ Yes 2 🕱 No	Hospital: 1 npa	tient 2 EP	∛Outpatien	it 3 🗆 🛭	Oth	9r: 4 □ Nu	irsing Hon	ne 5 Res	idence (	5 🗆 Oth	ner (Specify	1)	
=			27. Manner of Death 1   Natural 5 □ Pending	28a. Date of In (Month, D	jury 28 Day Year)	Bb. Time of Injury		28c. Injury Work	at c?	2	8d. Describe	how injur	y occur	red		
5 .	death. ctor; A y the fu	ati	2 Accident investigation				M	10	Yes 2 □ I	No						
	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of I	njury - At home etc. (Specify)	e, farm, str	eet, facto	ry, office		2	8f. Location ( City or To			ber or Rura	l Route Nu	m <i>ber</i> ,
	orrail D															
	To the Hospital or Atlending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exar	nysician: To the bes	of examination	edge, death n and/or inv	occurre vestigation	d at the timen, in my or	ne, date an pinion, dea	d place, a	nd due to the	cause(s) date and	and ma	anner as st and due to	ated. the cause	(5)
:	the mple	Wed	one)	and manner	stated.			On Linner	- number			:)Od Dat		d (Marth	Day Vaarl	
1	S - × S		29b. Signature and title of certifier	e UP	MP.		-	9c. License	( ) ¬			zag. Dat	e signe	ed (Month, I	Jay, rear)	
,	^	9	" nuclas s. 1.	jare, 1	110.			D) C	46	6		MA	RCI	1-20	1,21	DOE
	1.7		30. Name and address of person who	completed cause of	M.O.	3a) (Type,	Print)	00	1012	R	+ "Ma	50	11.	1.16	1/ -	1776
Rec	,		31. Date filed (Month, Day, Year)	S2 Renis	strar's Signatur	9	all .	001 /	00	1301	1.1.10.		10100	7/4	101 6	1001
	Sta Regist	ate rar	MAR 3 1 200	6 Marie	strar's Signatur	6264	2									

SAWYER AUDREY

STRIDIRON JAMES A

		AMend item#20a-c,22,pe	ype or Print in	n <del>d</del> /Depa	artment of	Health and N	II Copies Iental Hy	Are Legible. giene	
		1 - State Registrar		Cer	tificate of	Death		Reg. No.	09978
		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	nath Day Year	3. Time of Death
Physici /Medi		James A. Stridir	on				MARC		- 1 16 D M
Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death		4c. County of Dea	ath
		St. AGNES	Hospita	L	139	1timo	RE		
Funeral		Social Security Number     6. Sex	M 2DE	s. last birthday)	If Under 1 Yea Months Days	r If Under 24 Hrs. B Hours Min.	8. Date of Bir (Month, Da	th sy, Year) 9. Bi	rthplace (State or Foreig ountry)
Director		220-64-6037	50	Yrs.			Sept 26	5, 1955 Was	hington DC
pue *		Usual Residence of Decedent  10a, State 10b, County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
Aaryl Sho	0	MD	T	Baltimor	٠.				1√2 Yes 2 □ No
28a-	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
with with	by Funeral Director	616 Dukeland Stre	et			216		USA	
ne 23	ега	11. Marital Status	2. Was Decedent Ever in	U.S. 13. \	Was Decedent of	Hispanic Origin? (Saban, Mexican, Puerto	pecify Yes or No	- 14. Race - Am	erican Indian,
fer a	필	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1			Rican, etc.)		
urs a	by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give <sup>X</sup> Year or Dates:		1⊡Yes 2∑∏ No	o Specify:		Specify: b	lack
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinat must be notified at ance.	ted	15. Decedent's Educ		16a. Deced	dent's Usual Occi	upation e during most of worl	vina.	16b. Kind of Business	s/Industry
Ned Y	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	DO NOT use retir	ed)	ung.		
od wij	Completed	9	0	disa	bled			none	
al Hygid d other	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
should be t and Mental I s marked or sumatic svs	To	Carl Stridiron				Louella	Granam		
and and le ma	7.3	19a. Informant's Name/Relationship (Ty)				at and Number or Ru nd Street		er, City or Town, State, re. MD 212	
and ealth n 27		Louella Stridiro				id Street			
of H of H its		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	<i>y</i>	. Place of Dispo cemetery, cren	sition (Name of natory or other pi	ace)	Date	20c. Location - City o	r Town, State
Pag ment snt::		4 □Donation 5 ₩Other (Specify)	in state M	Mt. Carmel		4/4/2	006	Dundalk, MD	11 100-11
permit. Dep. rig	1	21. Signature of Funeral Service Uicense Ronald	ade Virget	or st	Name and Add	ress of Facility KC	uaiu y St	ayson Funeral Baltimore	Stree North
207 2 2 9	P 17	June 1	Mull		altimore		)1		I WA CO
		23a. Part1. Enter the disease, or compli- shock, or yeart failure. List only on	cations that caused the de e cause on each line.	eath. Do not ent	er the mode of dy	ring, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Pneum Due to (or as a cons	ocusti	e Car	inii fre	umo	mia	Months
/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					Turne or
LXammer	L	Sacuantistly list conditions b	##						120073
pe #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence ot):					
oe executed cian and ourial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	editence of).					
be ey ician buria	1								
death certificate be e) attending physician I for use as the buria	Physician/Medica	d	•						
ding se as	₩e	IF FEMALE:	3c. If yes, outcome of preg	nancy				23d. Date of de	alison.
atten for u	ian	in the past 12 months?	1 Live birth 2 □ Fe	etal death 3	Ectopic pregnant Other (specify)			Month	Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		3 Other (Specify)				
Attending Physician: The law requires that the death certificate be executed rideath.  sctor: Atter this certificate has been signed by the attending physician and by the tuneral director, page 2 should be deteched for use as the burial-transit	F.	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause g	jiven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
signed I	d by						10	Yes 2√ No 3 F	Probably 4 Unknow
w require been sig should b	ete						24a. Was	24h Word	utoney findings availab
has has	Completed						auto		autopsy findings available completion of cause of
ilcisn: The l certificate ha rector, page							1 ☐ Yes		s 2 No
ysicism: is certific director,	Be	25. Was case referred to medical examiner?	ospital: 1. Inpatient 2	0.55%		26. Place of Dea	1/4 3/5		
Phys raldi	- T	1 Yes 2 No		☐ ER/Outpatier 28b. Time of	" 30 DOA	4 🗀 INGISHING FI		idence 6 Other (Sp how injury occurred	ecity)
ding Ph h. After th funeral	ţou	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	W	ork? □Yes 2□No		,,	
deat deat ctor: y the	lica	3 Suicide 6 Could not be	28e. Place of Injury - Al	t home, farm, str			28f. Location	Street and Number or F	Rural Route Number.
after Dire	ertification:	4 Homicide determined	building, etc. (Spe	ecify)	551, 125151y, 51115			wn, State)	,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the funer	O	29a. Certifier 1 (☐ Certifying Phys	icken: To the best of my k	mowledge, deat	h conumed at the	time, data and place	and due to the	rausa(s) and manner i	as stated.
S Ho S Full letely	dicai	(Check only 2 Medical Examination)	or: On the basis of examinand manner stated.	ination and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place, and du	ue to the cause(s)
Nithin Fo the	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Mor	
->-0		> Sanjay	iyoner	om		P17495		03/23/06	
	3	30. Name and address of person who co	mpleted cause of death (II	tem 23a) (Type	Print)			03/23/06	
	1	30. Name and address of person who constant and address of person address of person address o	JAMARAM		900 cat	on Ave.	Baltin	more, MD	21229
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sit	nature	No.				
	rar	MAR 3 1 2006	RESERVED SO	F					

		Please T Amend item#8,perF	ype or Print i H. (853, 3/31 State of Mary	in Black	Indelible Ink	k. Ensure Al Health and M	l Copies	Are Legible.	1
		1 - State Registrar	- Clate of Mary		Certificate of		R	eg. No.	119979
Physicia /Medic		Decedent's Name (First, Middle, Last)     LESTER		Ι.	S	INGER	2. Date of Dea Month MARC	Day Year	3. Time of Death 7:38 A.M.
Examin		4a. Facility Name (If not institution, give s SINAL HOSPITA:		TIMORI		or Location of Death		4c. County of Dea	N/A
Funeral Director		5. Social Security Number 6. Sex 213-12-3611		yrs. last birth 86 Yr	day) If Under 1 Year		8. Date of Birth (Month, Day SEP 9	9/19/19199. Bi 1919	thplace (State or Foreign ountry) MD
aryland show		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
with the Maryland is or 28s-f show	Director	MD BALTIM  10e. Street and Number	IORE	B.F	LTIMORE 10f. Zip Code			0g. Citizen of What C	1 Yes 2 No
23a or	rai Di	4784 BYRON ROAD				21208			USA
urs after death ai', or items 23 Examinar musi	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XX Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 M Yes 2 ☐ No If Yes, Give Year or Dates:	WWII	<ol> <li>Was Decedent of If Yes, specify Cut</li> <li>Yes 2 No</li> </ol>	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
within 72 hours after ene." natural', or ite ne Medical Examin	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12			ecedent's Usual Occu Give kind of work done ife. DO NOT use retire FINISHER	during most of worki	ng	16b. Kind of Business	/Industry
illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, i		DIAMOND
d 2 should be th and Mental 7 is marked ( treumatic ev	To	ALEX  19a. Informant's Name/Relationship (Type	pe, Print)		NGER Mailing Address (Stree	RHEA	l Route Number	City or Town, State,	DIAMOND  Zip Code)
t and 2 Health a om 27 is		MICHAEL SINGER /			882 DEANWOO			RE, MD 212	
Pages nent of the nent of the net. If ite		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery,	crematory or other pla	1C8)			ORPE, MD
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	Cuttle		22. Name and Addr			SON & BROS	
bū icie	ical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Saluentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of	: RACT INF	r	r respiratory arr	est,	Approximate Interval Between Onset and Death 3 DAYS
requires thet the death certificate toen signed by the attending physic hould be deteched for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ży		23d. Date of de Month	livery Day Year
w requires thet been signed b should be dete	ed by Ph	Part II. Other significant conditions con - DIABETES	tributing to death but no	ot resulting in t	ne underlying cause g	ven in Part I.		pacco use contribute t	o the cause of death?
The law ate has b page 2 s	Completed by	- HYPERTEN	SION				24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ysicien: Th	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1   Inpatient	2 ER/Outp	atient 3 DOA	26. Place of Death her: 4 ☐ Nursing Hor		ence 6 ⊡Other (Spe	ecify)
To the Hospitel or Attending Physicien: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of beath  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Ye	At home, farm	iry Wo	ry at prk? Yes 2 No	28d. Describe ho	ow injury occurred  reet and Number or R	
To the Hospitel or within 24 hours effer To the Funerel Dir completely filled in			building, etc. (S		Seath occurred at the t	ime date and place :	City or Town		o stated
the Hos hin 24 h ths Fur npletely	Medical	(Check only 2   Medical Examin	ner: On the basis of exa and manner stated.	mination and/	or investigation, in my	opinion, death occurre	ed at the time, d	ate and place, and du	e to the cause(s)
V Viii	-	29b. Signature and title of certifier.	MOOLDH			se number RES – 00		9d. Date signed (Mon	
P		30. Name and address of person who con	mpleted cause of death	(Item 23a) (T	(pe, Print)			ILTIMORE	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signaturë	de .	-, -, 1110			and the state of t
Registr	ar	MAR 3 1 2006	plante &	2. Page					

			For State And Registrar	end Items	State of 1 24a - 29	Marylan <b>9a per</b>	d / Depa <b>Dr <sub>O</sub>g</b>	artmen 1532 Tillicali	t of H	lealth and I 1/06dhb eath	Mental Hy	giene Reg. No.	106	09980
1			1. Decedent's Nam	e (First, Middle, La	st)						2. Date of De	ath		3. Time of Death
	Physic /Medi		Gertrud	e M. Sim	on						Month	Day 20	Joo 6	4:37 AM
	Exami		4a. Facility Name (i	If not institution, giv	e street and number	er) (		4b. City,	Town, or	r Location of Death		1	unty of Death	1
			BALTIMORE		TON MEDIE	AL LE	NTER	GI	EN	BURNIE		AN	NE ARI	NOEL
	Funeral		5. Social Security N		Sex 7. I□M 25☑F	Age (In yrs. I	•	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Yəar)	Cour	place (State or Foreign
	Director		212-42-6	711	X	62	Yrs.				May 28	, 1943		yĺand
	and w		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation					1	0d. tnside City Limits
	Many	jo	MD	Anne Ar	undel		Glen B	urnia						1 ☐ Yes 2√ No
	28a	Director	10e. Street and Nu		under		JICH D	10f. Zip				10g, Citizer	of What Cour	
	3a ol	<u></u>	11 B I	Beach Roa	d				2	21061		_	USA	,
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f ehow he Medical Exercitor met the notified at	Funerai	11. Marital Status		12. Was Decede	nt Ever in U.	S. 13.	Was Deced	lent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14.	Race - Americ	
c	or Its	Ē	1 Never Marr	ied 2∏ Married	Armed Force			_			o Rican, etc.)	1	Black, White,	
6	ours Feb.	a by	3 Widowed	4 Divorced	tf Yes, Give Year or Date	s:		1 ☐ Yes	ZKI NO	Specify:		Sp	ecity: whi	te
1215-0036	72 h	Completed	(Spec	15. Decedent's E	ducation ade completed)		(Give	dent's Usua kind of wor	rk done d	during most of wor	king	16b. Kind	of Business/In	dustry unk
_⊃ <u>Z</u>	of thin	I de	Elementary/Seco	ondary (0-12)	Cotlege (1-4d	or 5+)		DO NOT us		•				
	Hygie Hygie ont, to		17. Father's Name	/First Middle 1 ast	0			lata p	roce	essor 18. Mother's Nan	no (Eirek Middle	Maida - C		
(A)	d be do do	Be									cude Isa		,	_
Q 5	should nd Men marke	2		George R:			19h Mailir	na Address	/Street :	and Number or Ru				
GERT Maryland	end 2 sealth ar m 27 le			imon/spou						Road Gle			21061	Code
5 0	Hea Item		20a. Method of Dis			20b. Pt	tace of Dispo	sition /Nan	ne of	1	Date		ion - City or To	own, State
SIMON	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Exaction must be notified at ance.		4 🔀 Donation	5 ☐ Other (Special		te 7	emetery, crei	matory or o	tner plac	(e)				
S #	permit. Departr Importany Inju		21. Signature of R	onald S	Wade Vi	, Peter		Name and Ate A		ss of Facility Omy Board MD 2120		Balt	imore S	treet
			23a. Part1. Enter t	the disease, or com	plications that caus one cause on each	sed the death						rrest,		Approximate
	Physician		Immediate Cause	(Final			- / R	2000	) (	- D.				Interval Between Onset and Death
	/Medical		resulting in death)			HROU as a consequ		01357	ala	100 Pa	Lahowah	4 61	SEYSE	
	Examiner		Sequentially list co	aditions	b	RESP	IRAT	DRY		FAILUR	LE			
	D #	ner	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or	as a consequ	ience of):							
	ecute and trans	Examiner	Cause (Disease or that initiated events resulting in death)	S	c									
9	cate be executed physician and the burial-transit	<u>E</u>	,		Due to (or a	as a consequ	ience of):							
68760	physicate the last	dical		•	_ d									
	E Ones	Physician/Me	IF FEMALE:		23c. If yes, outcor	ne of pregnar	ncv							
Box	atten for u	cian	23b. Was deceden in the past 12	months?	1 ☐ Live birth	2 Fetal	death 3	Ectopic pro				23d	. Date of delive Month	ery Day Year
0	the d y the	ysi	1 ☐ Yes 2 { 9 ☐ Unknown		9□ Unknown		JE. 17	1 Other (spr	BC1/y/					
	w requires that the death centered in the death centered is signed by the attending should be detached for use	by Pr	Part tt. Other signif	ficant conditions	contributing to death	but not resu	ılting in the u	nderlying ca	ause give	en in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
29ac	turres n sign										10	Yes 2□N	lo 3 Prob	ably 4 Unknown
000	s bee	lete									24a. Was	an 2	4h Were auto	nev findings available
, 00	The law cate has page 2 a	Completed									autop perfo	rmed?	death?	psy findings available apletion of cause of
74a Vital	ilcian: Th certificate rector, pag	Be C	25. Was case refer	red to medical						26. Place of Dea	1 Yes	20 No	1 🗆 Yes	2 No
25 X	Physician: this certific	To B	examiner? 1 Tes 2	No	Hospital:	ıtient 2 ☐ 8	ER/Outpatien	nt 3□ DO	A Othe		ome 5 Resid		Other /Specifi	<i>(</i> )
7 0			27. Manner of Deat		28a. Date of to		28b. Time of tnjury		8c. tnjury Work		28d. Describe I			·/
Z	Attending r death. ector: After by the funer	atic	1 Naturat 2 Accident	5 ☐ Pending investigatio	n	, ou.,	anjury	М		Yes 2 □No				
Division	or Attendenter de Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At hore	me, farm, str	eet, factory	, office		28f. Location (S City or Tox	Street and N	umber or Rura	Route Number,
	urs ef		00 0 "											
	To the Hospital or Attentivities within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical Exe	nysician: To the be niner: On the basis and manner	of examinati	wledge, death ion and/or in	n occurred a vestigation,	at the tim in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as st ice, and due to	ated. the cause(s)
	To the within 2 To the complet	2	29b. Signature and	title of certifier	•/			29c	. License	e number			gned (Month,	-
			P	Jer				1	200	5570	3	Mar	ch 20	,2006
	5				completed cause o				7.20					/
			31. Date fited (Mon		SHING-TON 32 BOOT	MCD1		CENT	LIL,	6 LEN	BURNI	E n	11	
	St: Regist	ate rar	MAF		AP N	Ag	Anant	60						
			WA	8.3  0.2006	L'A Malera	Set "	AND THE PERSON NAMED IN							

State of Maryland / Department of Health and Mental Hygiene ] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 CATHERINE D. TEBO Month Year **Physician** March 30, 11:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of the Chesapeake Care Center Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F 84 219-28-9349 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the McClost Examinational be notified at 1 Nes 2 No N/A Maryland Baltimore Direct 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3800 Brooklyn Avenue 21225 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Cepariment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 □ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesperson Hess Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Susie Henkel Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Murphy (Daughter) 3800 Brooklyn Ave., Baltimore, Maryland 21225 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4/ injury \* 4 □ Donation 5 □ Other (Specify) 3 /06 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker any in McCully-Polyniak Funeral Home, P.A. 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENS TIM ENOSZAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transil Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Unknown NEUMONIA Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? 2 10 Division of Vital Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1105 ... 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3∏ DOA s after death.
I Diractor: After this d in by the funeral d this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2' Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 | Homicide 24 hours 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03/20/2006 125506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 Potee St., Baltimore, Maryland Dr. Fer Eren, M.D. 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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AKG			State Registrar	,		<i>C</i>	ertificate of	Death		Reg. No.		
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	Examin		4a. Facility Name (If not institution, g 8034 Neighbors		um <i>ber)</i>		4b. City, Town, o	or Location of Death		4c. County of Balti		e County
2	Funeral			. Sex	7. Age (/	n yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bird	th V Your	9. Birth	nplace (State or Foreign
33	Director		213-94-0518 Usual Residence of Decedent	1 <b>X</b> M 2□ F	28	Yrs.	Months Days	Hours Min.	Feb. 1	1978		Maryland
	yland		10a. State 10b. County		10	Oc. City, Town or	Location					10d. Inside City Limits
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	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Cou	untry?
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336	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	ive		1 ☐ Yes 2 💢 No	Specify:		Specify:	Bi-	racial
9	2 hou	ted	15. Decedent's (Specify only highest		0	16a. De	cedent's Usual Occu	pation	kina	16b. Kind of Bu	siness/l	ndustry
215	thin 7	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life	DO NOT use retire	ed)	9			
121	lygier her th		G.E.D.  17. Father's Name (First, Middle, La	at)			Unemplo		a /First Middle	N/A Maiden Sumam		
and	il be fi	Be	Warrace N. Tee						ret E. E		'/	
Maryland 21215-0036	is 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or Itema 23a or 28a-f show other treumatic event, the Medical Examinal mant be multified at	၉	19a. Informant's Name/Relationship	·		19b. Ma	ailing Address (Street				State, Z	Tip Code)
N S	nd 2 state are treu		warrace N. Teel		ather	2) 80	34 Neighbo	ors Ave	Rosedal	Le. Mary	2ano	l 21237
<u>5</u>	s 1 a Hea Item othe		20a. Method of Disposition				sposition (Name of crematory or other pla		Date	20c. Location -		
Ĕ	Page nent c int: if		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		n State		Crematori	3/31	/2006	Baltimo	ire.	Maryland
Baltimore,	permit. Pages 1 and Department of Heali Important: if item 2 eny injury or other <u>page</u> .		21. Signature of Funeral Service Li	censee			22. Name and Addr	ess of Facility Sci	himunek	Funeral	Hom	ne Inc.,
_	20229		Com the	70			3331 Brehn	ns Lane, 1	Baltimor	ie, Mary	<u>'and</u>	1 21213
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P.O.	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk			3 <u> </u>					
٥.	s that ned b e deta	by PI	Part II. Other significant condition	s contributing to	death but i	not resulting in th	e underlying cause g	iven in Part I.	23e. Did	tobacco use contr	bute to	the cause of death?
rds	quire an sig	ed b							1 🗆	Yes 2□No	3 ☐ Pri	obabiy 4 🗆 Unknown
ဝ၁	law re as bed 2 sho	Completed							24a. Was	DSV D	Vere au	itopsy findings available completion of cause of
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/ita	clen: ertific actor,	Be	25. Was case referred to medical examiner?	Hospital:			0	26. Place of Dea	ath (Check only	one)		
of.	Physi this c	2	1 XYes 2 No 27. Manner of Death	1 L	Inpatient					idence 6 20th		at scene
- E	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investiga		e of Injury onth, Day Y		rv Wa	ork?` ⊒Yes XXXNo	unk		,,,	
Division of Vital Records,	Atten r deat octor: y the	fica	3 Suicide 6 Could no	t be 28e. Plac	ce of Injury	- At home, farm	street, factory, office	)	28f. Location (	Street and Numb	er or Ru	ural Route Number,
Div	s affer	Certification;	4  Homicide	hom	lding, etc. ( IC	(Бресіту)			Rosedale,	, MD	· Neı	ghbors Ave.
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (		caminer: On the		xamination and/o	eath occurred at the r r investigation, in my					
	othe othe	Med	29b. Signature and title of certifier	^ ′	1		29c. Licer	nse number		29d. Date signed	(Mont	h, Day, Year)
	⊢≯⊢ō		1/1 Min	wholh	DILA	()		O.C.M.E.		March	28,	2006
			30. Name and address of person w	ho completed ca	use of dea	th (Item 23a) (Ty	pe, Print)	Q	D 1 · ·	3.5		21201
_			J. UA/ENW	YEM	W	)	III Penn	Street,	Balt1mor	re, Mary	and	21201
		ate	31. Date filed (Month, Day, Year)	32.	Registrar'	s Signature						
	Regist	rei	WAR 3 1 20	Ub A	48	A Ass	self 1					

		•	For State Registrar	State of Maryla			nt of He te of D		Mental Hy	/giene Reg. No	CUUL	99983
	Physici	an	1. Decedent's Name (First, Middle, Last	1.					2. Date of D Month	Da		3. Time of Death
	/Medic	al	Sharon Agath  4a. Fecility Name (If not institution, give			4h Cit	v Town or	Location of Death	3	28	County of Death	
1	Examin	er	Casey House	sires and rames,		0	nen	200211011 01 2001			hontgon	
	Funeral Director		000 0. 05.0	X ☐M 2MF 7. Age (In yr	s. last birthday) 43 Yrs.	If Und Month	er 1 Year Days	Il Under 24 Hrs. Hours Min.	8. Date of B	irth av. Year)	9. Birth	place (State or Foreign ntry)
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation						10d. Inside City Limits
	Maryl	to	MD montgo	mery S	ilver:	Spr	ing					1 ☐ Yes 2 No
	or 28e	lrec	10e. Street and Number			10f. 2	ip Code			_	tizen of What Cou	ntry?
	ath wi	rail	1516 Gridley La				3902		Total Was a N		maica	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow other traumatic event, the Mudical Examinations be notilled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 ☐ Yes	ecify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	реслу тез от N o Rican, etc.)	0-	14. Race - Ameri Black, White Specify:	
2 2	72 hor	eted	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Us	ual Occupa	tion uring most of wor	king	1	(ind of Business/Ir	
21215-0036	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not 1691	use retired)			S	elf En	ployed
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/lan	should be and Mental marked o	To B	Unknown					Elvie	Vern	on		
Maryland	12 sho h and l 7 is ma		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	- 4					or Town, State, Zi	o Code)
	ges 1 and 2 it of Health if Item 27 i		Davinia James/ 20a. Method of Disposition	206	. Place of Dispo	sition (N	ame di	me-Silve	Date	20c. L	ocation - City or T	own, State
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Baltimore,	permit. Page: Depertment of Importent: If I eny Injury or once.		21. Signature of Funeral Service Licens	500	22	2. Name	and Address	s of Facility Ro				ionservices
	405 a		23a. Part1. Enter the disease, or comp	m013:							WDSOOL	Approximate
· A	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Metasta  Due to (or as a cons	tic Bre							Interval Between Onset and Death
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			IF FEMALE:								- 31	
P.O. Box	the death certific: y the attending pl ched for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	⊒Ectopic ⊒ Other (	pregnancy specify)		- 200		23d. Date of deliv Month	rery Day Year
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Division of Vital Records,	ding Physicien: The law requiri h. After this certificete hes been si funeral director, page 2 should t	Completed							24a. Wa auto per 1 ☐ Yes	opsy formed?	prior to co	opsy findings available ompletion of cause of
ital	ilen: ortifice ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea			, , , , , ,	
<u>₹</u>	Physicien: r this certific ral director,	မ	1 ☐ Yes 2 反 No		☐ ER/Outpatie			4 Nursing F	1		6 ☐Other (Spec	rfy)
ono	ding F h. After funera	tlon:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year,	28b. Time o Injury	M	28c. Injury Work 1 🗌 Y	at ? ′es 2 ⊒No	28d. Describe	now inju	ury occurred	
Divisi	To the Hospitel or Attending within 24 hours efter death.  To the Funerel Director: Attencompletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined		home, larm, st	reet, fact	ory, office		28f. Location City or To	(Street a	nd Number or Rui e)	al Route Number,
	To the Hospitel of within 24 hours of To the Funerel D completely filled in	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kiner: On the basis of exam and manner stated.	nowledge, deat ination and/or in	h occurre vestigati	ed at the tim on, in my op	e, date and place sinion, death occu	a, and due to the urred at the time	e cause(s e, date an	s) and manner as nd place, and due	stated. to the cause(s)
•	with To t	Σ	29b. Signature and title of certifier			2	9c. License	number			ate signed (Month	
	$\cap$		Paul Barmen				MD 06	0335		5	29-01	0
	7	4	30. Name and address of person who of Paul Bannen 327	completed cause of death (I Prince Phill:	tem 23a) (Type, Lp Dr. (	Print) Olne	y MD 2	20832				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig								



06-021 crn	44	Ţ	Please Inpend iten#23a,27,28a- 1- State	f perME, C8' State of M	larylan		artment of I tificate of				06	09984
	- N-1		Registrar  1. Decedent's Name (First, Middle, La	st)		- 00/	incate of	Doain	2. Date of Death			3. Time of Death
	Physici /Medio		HOWELL A	PE	WI	LLIA	m. S		March	2 7	2ŎÖ6	10:01 P M
	Examir		4a. Facility Name (If not institution, giv 2516 Sparrows Poi	e street and number				or Location of Death		_	ty of Death	
36	Funeral		5. Social Security Number 6. S			last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
5	Director		Usual Residence of Decedent		50	y, Town or Lo			Aug. 7,	1955	Md.	10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified.	tor	Md. State 10b. County Balti	more		Roseda						1 ☐ Yes 2X No
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36	irs after	by Fur	1 Never Married 2 Married 3 Widowed 4 XDivorced	Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	<b>ď</b> √o		1 Tes, specify Cub 1 ☐ Yes 2 🛣 No		rican, etc.)		<sup>ack,</sup> White, <i>ify</i> : Whi	
9-0	2 hou	ted	15. Decedent's E			16a. Dece	lent's Usual Docu	pation	ng 1	6b. Kind of	Business/Ir	ndustry
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5	il Hygi other	Be Co	17. Father's Name (First, Middle, Last	)		1 110	HOLITOL	18. Mother's Name	(First, Middle, M	laiden Suma	ame)	
ylar	Menta Menta arked atic e	10	Herbert Willia						a Linze			
Mar	12 sh th and 7 is m traum		19a. Informant's Name/Relationship ( Diana Seebode	Type, Print) sister				t and Number or Rura Ave. Rosed		-	n, State, Zij	o Code)
	s 1 and I Healt Item 2 other		20a. Method of Disposition		1 6	Place of Dispo	sition (Name of natory or other pla		Date 2	Oc. Location	- City or T	own, State
<u>n</u>	Pages nent of ant: If I		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				Cremator		l 1, 006'	Balti	more	
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Siol	uttendir death. ctor: Al y the fu	catic	2 Accident investigation 3 Suicide 6 Acould not be	n 3/27/2006			M 1		ink			
Divi	lor At after d Direct in by	Certification:	4 Homicide determined	building,	etc. (Specia	ome, farm, st	eet, factory, office		28f. Location (Str City or Town, Edgemere,	State) 25	l6 Spar	ra <i>l Route Number,</i> crows Point Ro
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	miner: On the basis	t of my kno	owledge, deat ation and/or in	n occurred at the t vestigation, in my	time, date and place, opinion, death occurr	and due to the ca	use(s) and	manner as	stated. to the cause(s)
	othe vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner s	stated.		29c. Licer	nse number	29	d. Date sign	ned (Month	, Day, Year)
	F > F 0		> Chu	Br				O.C.M.E.	I	March	28, 2	2006
			30. Name and address of person who					001+ima	Marari	4 0100	)1	
	Sta	ate	J. Laron Locke, N 31. Date filed (Month, Day, Year)	32 Ragis	trar's Sign:	ature	-	Baltimore,	пасутап	1 212	/ <b>L</b>	
	Regist	rar	MAR 3 1	2006	July 1	M	back					

ORIGINAL

		1	For State Registrar	State of Maryland		nt of Health and te of Death	Mental Hygien		09985
	Dhysiai	W -	1. Decedent's Name (First, Middle, Last)	ATCOM			2. Date of Death Month D	ay Year	3. Time of Death
. 40	Physicia /Medic	al -	DOKH W	ASON				7 2006 c. County of Death	3.00 PM
	Examin	er	la. Facility Name (If not institution, give str	eet and number)	46. City	Town, or Location of Deat	n 4	C. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		r 1 Year If Under 24 Hrs		9. Birthp	place (State or Foreign
	Director		213-26-6309 101	120 F 9	Yrs. Months	Days Hours Min.	6-30-19	107 Vir	ginia
	and w	. ⊢	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				0d. Inside City Limits
	Maryli fed a		MD N/A	7-	Paltimo.	rP			1 XYes 2 □ No
	r 28a	Director	10e. Street and Number		10f. Zi	p Code	10g. (	Citizen of What Cour	ntry?
	ours after death with the Marylan rai', or Itema 23a or 28a-f show Examiner must be notified at		2919 Ellico7	7 Drive		21216		USA	
	er des Itema	Funeral	T. Maria States	!. Was Decedent Ever in U.: Armed Forces?	S. 13. Was Dece If Yes, spi	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 □ Yes 2 ▼No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: Bla	CK
5-0036	72 hours after death with the Maryland natural; or Itema 23e or 28e-f show Sical Examiner must be motified at	eted	15. Decedent's Educa (Specify only highest grade		16a. Decedent's Usi	ork done during most of wo	rking 16b.	Kind of Business/In	dustry
2121	d within 72 ho piene. r than "natur ine Macical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DO-NOT	use retired)	1	Divite	1/4000
	be filed v ital Hygie id other t	e Co	17. Father's Name (First, Middle, Last)	0	2011		me (First, Middle, Maid	en Sumame)	HOME
an		To Be	Babel Watson	1		ANN	io Stoke	/V	$\smile$
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type	e, Print)	AD	s (Street and Number or R		,	
-	s 1 and 2 if Health Item 27 other tra		Mrs Geraldine B	ailey		MICOTTL		Location · City or To	5.21216
Jore	90 = 5		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	lace of Disposition (Na emetery, crematory or	other place)			55.5
Baltimore	permit. Pag Department Important: any Injury ence.	1	4 ☐ Denation 5 ☐ Other (Specify)  21. Signatury of Funeral Service Licensee	116	22. Name a	and Address of Facility	5-2006 D	UNICHE	M De
B	Ded Jan P		Jaseph S. Mi	iss	2222	ond Address of Facility  OPH L RUSS  W. NOrth A	UE. Baltim	ore, Md.	21216
Ve.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Myocarde	af wife	isetion			Onset and Death
	/Medical Examiner		resulting in death)	Due(to (or as a consequ	uence of):				
	1 × 1	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):				
V	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.						
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):				
9289	ate hy:	Physician/Medical	d.						
Box 6	eath certific attending p I for use as 1	√Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna	ncy			23d. Date of deliv	ery
	death e atte	lcia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown				Month	Day Year
О. О.	that the de led by the a	Phys	9 Unknown			saves gives in Cost I	23a Did tohaco	o use contribute to I	the cause of death?
	ires tha signed I be det		Part II. Other significant conditions cont	I / 1 & C /	I Re Indenying	LIAO AL			bably 4 ⊠Unknown
of Vital Records,	w require been si should !	Completed by	- January Company		<u> </u>		24a. Was an	24b. Were aut	opsy findings available
Rec	The law ate has page 2	dmc					autopsy performed	prior to co death?	empletion of cause of
ta	(0	Be C	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☑ eath (Check only one)	NO TOTOS	2010
<u></u>	Phyaician: rthis certificanal director,	10 B	examiner? 1 Yes 2 No	spital: 1   Inpatient 2	ER/Outpatient 3 0	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Speci	fy)
	ding PI h. After ti funera		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
Division	Attending ir death. ector: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	M ome farm street factor	1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rui	al Route Number,
οi	after after I Dire	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y) -,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St	ate)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			count To the best of my know; On the basis of examina					
	the H hin 24 the F nplete	Medical	one)	and manner stated.		9c. License number		Date signed (Month	
<b>\</b>	To To		29b. Signature and title of certifier			D3912	7	3/30/2	006
7	0.		30. Name and address of person who cor	npleted cause of death (Iten	n 23a) (Type, Print)	.) ) (12	18.	12	
	Y		A AHMEDMD	821 N- E	elew s	reet Ba	umore	MD 3	1201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 1 2	32. Rajistrar's Signa	ture, Joseph				

			For	State of Maryland	•		Mental Hygie	ne	
			1 - State Registrar		Certifica	ate of Death	Reg.	No. U U	19986
	Physici	an	Decedent's Name (First, Middle, Last)	1 2			2. Date of Death Month	Day Year	3. Time of Death
Sec. 17	/Media	cal	Maude WII	iams	41. 6:			15 2006	, /1:3/ M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)	46. Ci	ty, Town, or Location of De	ain	4c. County of Death	n
			5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) If Und	Jactimore Jer i Year I II Under 24 Hi	s. 8. Date of Birth	9 Birth	nplace (State or Foreign
В	Funeral Director			M 20 82	Yrs. Month	s Days Hours Mi	n. (Month, Day, Ye	ar) Coi	Unitry)
	D D		Usual Residence of Decedent				X 011	744	7. 311114
	irylan	_	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Ba-f e	cto	md N/V	4 B	altimo	ore			1 Kes 2 No
	vith th	Director	10e. Street and Number	. 11.	10f. 7	Zip Code	10g.	Citizen of What Cou	untry?
	s 234	erai	≈195 12 · 111€	2. Was Decedent Ever in U.S	13 Was Day	cedent of Hispanic Origin?	Specify Ves or No	14. Race - Amer	rican Indian
	ther d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	If Yes, s	pecify Cuban, Mexican, Pue	orto Rican, etc.)	Black, White	
93	urs a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: A	ack
5-0036	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f ehow ha Modical Examinar must be motified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's U	sual Occupation work done during most of w	16b	. Kind of Business/l	ndustry
21	thin 19	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	Orking	2 - 1	. 1
7	filed w Hygier other th		[2]	0	Dom	eslic		rivate	Home
and	be fill H and off	Be	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, Maid	ien Sumame)	
<u>~</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f ehow aumatic event, it a Madical Examiner must be notified at	1º	Frank Dol	uman	Nach Mallian Add	<u> </u>	The La	MPRIV	2-1-1
Maryland	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Typ	11.	n n n - 1/	ess (Street and Number or I	- DII .	0.1	Ip Code)
	of Health Item 27 other tra		20a. Method of Disposition	IIIams 20b. Pla	ace of Disposition (A	INCAIOMEC		Location - City or 1	Z / Z / S Town, State
altimore,	00		1  Burial 2  Cremation 3  R 4  Donation 5  Other (Specify)	emoval from State	metery crematory o	or other place)	Isalai F	30 Him	-2 MA
₫	그 문문 급		21. Signature of Funeral Service License	97 V([]	22. Name	and Address of Facility	30/06 1	1	re, MD.
Ba	Depart Depart Import any Inj		Jaseph L. A	1111	Jose	phl. Russi 2 W. North A		me P.A	
1 8			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	Do not enter the m			71101 6, 11	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	Cancel	. /			Onset and Death
ž	/Medical		resulting in death)	Due to (or as a conseque	00.11				
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	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):		*		
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687	ficate physics the	edicai							
Box	at the death certific by the attending p stached for use as	N/	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnan				23d. Date of delin	very
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	as th	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resul	lting in the underlying	g cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
ğ	w require been sign	ted					1 🗆 Yes	2 0 No 3 □ Pro	obably 4 Unknown
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<u>~</u>	nysician: The law his certificate has t I director, page 2 s	Co					performed 1 □ Yes 2 □	? death?	2 No
/ite	cian	Be	25. Was case referred to medicat examiner?	nonital:		1 -	eath (Check only one)		
0	Physi this c	2	1 Yes 2 No	1	R/Outpatient 3		Home 5 PResidence		afy)
חם	ding P h. After I funere	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how is	njury occurred	
S	deatl deatl ctor: y the	fica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon			28f. Location (Street	and Number or Ru	rai Route Number
<u>≤</u>	after after Dire	Certification:	4 Homicide	building, etc. (Specify)		0.7, 0.1100	City or Town, St		ar r touto r ambor,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	aic	29a. Certifier La Certifying Phys	ician: To the best of my know	vledge, death occurre	ed at the time, date and pla	ce, and due to the cause	s(s) and manner as	stated.
	he Ho in 24 he Fu	edical	(Check only 2 Medical Examination)	er: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion, death oc	curred at the time, date	and place, and due	to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	10	2	29c. License number		Date signed (Month	
F			the the	()		0003912	7 3	-27-2	2006
	1)		30. Name and address of person who co		23a) (Typa, Print)	ST 20010.	7 3 more L	12 2/3	01
120	Sta	to	31. Date filed (Month, Day, Year)	32/Aegistrar's Signatu		·			/
100	Registr		MAR 3 1 200	16 Marie D	Lynn	•			

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** IRENE FRANCES WONNEMAN 9:45 AM March 28,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Months, Days Pear) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√2F 219-01-3936 86 Yrs. Märyland Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at MD Baltimore Director Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt.101 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: ģ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Dept. Of Social Administrative Assistant 12 Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Baker Ernest Charles Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Westfield Avenue, Baltimore MD 21214 David Wonneman-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mar.31,2006 Baltimore, Maryland Holy Redeemer Cemetery 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Sign yere of Funeral Service Licensee h. 18 1= 8800 Harford Road-Parkville,MD 21234 Cordrae tadder Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ncreatic Concer Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 W No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate hes been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C completely filled i Hospite Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bo 6/0

State Registrar 31. Date filed (Month, Day, Year)

2006

Baltimore, Maryland 21215-0036

38/06

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Records,

Vital

ot

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month cof **Physician** homas 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWSOR mmore If Under 1 Year If Under 24 Months Days Hours 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months -82-8310 Yrs. Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should ba filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 Is markad othar then "natural", or Itams 23a or 2 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use-retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispos Date tion 1 ☐ Burial 2 ☑ Cremation 3 DRemoval from State 5 30 Department of Important: If any injury or once. torest \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Addo to of Facility ternatives Funeral and Citmation York rd. Thonlum, mo 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melanoma **Physician** eals 181 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death cartificate be exacuted the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ director, page 2 should be 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: J. 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 🗌 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 🗌 Yes 2 1 No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide filled within 24 hours a To the Funeral L 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 32 30-06 who completed cause of death (Item 23a) (Type, Print) 5 + ONON MAD Suite 403 21204 1505 Orler M. Tanson 120 ber1

Registrar

State

31. Date filed (Month, WAR 3

Day, Year) 1 2006

Thomas, while

32. Registrar's Signature

			1 - For State Registrar	State of Man			of Health of Death		-	giene Reg. No.	) () (i)		39
	Physici	an	1. Decedent's Name (First, Middle, Last)						<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of	
	/Medic		Bernice	Watts		,			03	16	06	8:30	P M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tov	vn, or Location	of Death		4c. (	County of Deat	th	
			Manor_Care Nursir				resda 'ear   If Under	24 Hza			ontgom		
	Funeral		5. Social Security Number 6. Sex 1 □	7.Age <i>(li</i>  M.2√∑F	n yrs. last birthday, Yrs.		ays Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)	9. Birt	thplace (State o	r Foreign
	Director		579=34-7159 Usual Residence of Decedent	88	3			<u> </u>	07 0	7 17	Nor	th Caro	lina
	iand ow		10a. State 10b. County	10	Dc. City, Town or L	ocation						10d. Inside Ci	ity Limits
	Many fied	ţ	MD Montgome:	ry	Betheso	la						M∑Yes	2 🗀 No
	r 288	irec	10e. Street and Number			10f. Zip Co	de			10g. Citiz	en of What Co	ountry?	
	h wit	a D	6530 Democracy B	lvd.		208	817				USA		
	deal	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexica	igin? (Spe	ecify Yes or No	)- 1	4. Race - Ame Black, Whit		
õ	or lite	F	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 🛭					Specify: Bla		
ğ	within 72 hours after death with the Maryland ene. ene. then "naturel", or hems 23a or 28a-f show then "naturel" or hems 23a or 28a-f show then "natibe notified a	Completed by Funeral Director	3 X Widowed 4 □ Divorced	Year or Dates:									
7	"nat	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual O	lccupation lone during mo: etired)	st of work	ing		d of Business ersitv	of the	
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N.	filed Hygir ther ant,		17. Father's Name (First, Middle, Last)		Nuli	STIIE AS			e (First, Middle	, Maiden S	Sumame)		
Maryland	d be ental ked c	To Be	Robert Adams				Liz	710	J. Stor	۵			
2	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mail	ing Address (Si	treet and Numb				Town, State, 2	Zip Code)	
Ž	nd 2 alth a 27 Is r treu		Ollie Alston		121 1	harring	ton St.	C LI	Uach	D C	20032	)	
Baltımore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If them 271s marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examinar must be notified at once.		20a. Method of Disposition		20b. Place of Disp	osition (Name of	of !		Date	20c. Loc	ation - City or		
Ë	Page lent c nt: # ry or		1 Burial 2 □ Cremation 3 □ R  - 4 □ Donation 5 □ Other (Specify)		Cedar Hi	-		-28-	06	Suit	land. N	MOV.	
<u>=</u>	mit.		21. Signature of Funeral Service License		2	2. Name and A	ddress of Facil		rshall'		Commence of the Commence of th		
'n	Depared Depared Important in any ire		DP ma	ishall	4:	217 9th	. St. N						
			23a. Part). Enter the disease, or compli- shock or heart failure. List only on	cations that caused the								Approximate Interval Bets	e ween
	ากงารเราสกา		Immediate Cause (Final disease or condition	Alterosc	leretic 1	Hoart D	icone					Onset and [	Death
	/Medical		resulting in death)	Due to (or as a co		icart D	Isease						727
	Examiner		Sequentially list conditions	). =									
	р <del>=</del>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):								
	and and trans	Examiner	that initiated events cresulting in death) Last										
8760,	cian a	Ē	rooding in doding sacr	Due to (or as a co	onsequence or);								
8	death certificate be executed e attending physician and of for use as the burial-transit	dlcal	d										
9 ×	eath certific attending p I for use as I	Physician/Med	IF FEMALE:	3c. If yes, outcome of p	oregnancy						Od Data of da	li.e.	
Вох	atten atten for us	ian	in the past 12 months?	1□Live birth 2□ 4□Pregnant at tim	Fetal death 3	□Ectopic pregr □ Other (specif				2	3d. Date of de Month	-	Year
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3.	res that the signed by th be detache		Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	inderlying caus	e given in Part	1.	23e. Did	obacco us	e contribute to	the cause of d	death?
ecords,	og og	d by	Alzheimers						1 🗆	Yes 21	]No 3 □ P	robably 4 🗆 l	Unknown
Ö	> 0 0	lete							24a, Was	an	24h Were a	utopsy findings	available
Ř	has has ge 2	Completed							auto perfe	psy ormed?	prior to death?	completion of c	ause of
	i <b>cien</b> : Th certificate rector, pag	e Cc	25. Was case referred to medical				OS Elles	o of Dooti	1 Yes		1 🗆 Yes	2 □ No	
Vital		o B	examiner?	lospital:	2 ER/Outpatie	nt 3 DOA			n <i>(Check only</i> me 5 ☐ Res		Other (See	voifu)	
O	ig Phys ter this neral di	h-	27. Manner of Death	28a. Date of Injury (Month, Day Ye			Injury at		28d. Describe			cny)	
0	토 중 등 등	atlo	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	М	Work? 1 ☐ Yes 2 ☐	No					
Division	or Attendater death	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, st	reet, factory, of	fice			Street and wn, State)	Number or R	ural Route Num	nber.
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	To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	edical	29a. Certifier 1 Certifying Phys	sician: To the best of mer: On the basis of ex and manner stated	ny knowledge, dea amination and/or in I.	th occurred at to	he time, date a my opinion, de	nd place, ath occurr	and due to the ed at the time,	cause(s) a	and manner as place, and due	s stated. e to the cause(s	5)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	721 011		29c. Li	cense number			29d. Date	signed (Mont	th, Day, Year)	
	/		1/1/4	* neary	1	D52	691		,	vf A 1-	2/. 24	006	
1	1		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type		.U.J.L			TALCI	24, 20	000	
U			Ajay Reddy, M.D.				hesda,	MD.	20817				
	Sta Registr		31. Date filed (Month, Day, Year)	32, Redistrar's	Signature	docite							

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itema 23a ō Baltimore, Maryland 21215-0036 natural', d 2 should be filed withIn 7 th and Mental Hygiene. 7 is marked other than "r of Health ar

Vatson

Box 68760. P.O. Records, Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 24, Cleothedra 4:15 A M Wilson 2006 Watson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Heritage Harbor Nursing Home Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year)
Mar 25, 19 Birthplace (State or Foreign Country)
 SC **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Director 250-38-1452 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 A Yes 2 □ No Director Prince Georges Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 3637 Elder Oaks Blvd, Apt 8201 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Z¥No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: Black þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leola Washington Samuel Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Fleming - Niece 3637 Elder Oaks Blvd, Apt 8201, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Pages 1
Department of Hi Important: If iter any injury or oth 1 

Burial 2 

Cremation 3 

Removal from State \* 4 □ Donation 5 □ Other (Specify) 3/30/2006 Bethel Cemetery Georgetown, SC 21. Signature o Funeral Service Licenses 22. Name and Address of Facility Wilds Funeral Home 130 Merriman Road, Georgetown, SC (Ameun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carchomyo party Physician disease or condition resulting in death) many 415 /Medical Due to (or as a consequence of): Examiner In Sulus Dependent Diobate; Melli fris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Demente 475 Due to (or as a consequence of) Hy Berten From 415 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 WNo this 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attanding 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 29a. Certifier 1 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) み MO DO040519 3-25-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAZA M. NUSCITER, U. D. 1401 MADISON PARK, Glen Burnie, 21061, Mayland.

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

MAR 3 1 2006

2. Registrar's Signature

		•	1. For Stete	State of Ma		/ Depa	artment of	Health a	and Me	ental Hy	giene	06	09991
.7	Physici		1. Decedent's Name (First, Middle, Las	L- W	ling	19te	imouto o	Dogin	1	2. Date of De Month		Year 2006	3. Time of Death
	/Medic Examin	12.6	4a. Facility Name (If not institution, give				4b. City, Town	, or Location		1011011	4c. Co	unty of Death	
		<u> </u>	Harbor Hospi	tal			Baltin		24 Hrs. I			nla	
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1	m m -	(In yrs. ia:	st birthday) Yrs.	Months Day		Min.	B. Date of Bir (Month, Da June 7,	tn 19, Year) 1947	Cour	lace (State or Foreign htty) Land
	pur M		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					1	0d. Inside City Limits
	death with the Maryland ima 23a or 28a-f show	tor	Maryland Anne Aru		,		n Burnie	<u>:</u>					1 ☐ Yes 2 📉 No
	th the	Directo	10e. Street and Number				10f. Zip Code	•			10g. Citizer	of What Cour	ntry?
	230 c	ralD	7004 Aviation Blv					.061				ed Stat	
	be filed within 72 hours after death with the Marylan da Hygiene.  da Hygiene.  da Chfer than "natural", or Itema 23a or 28a-f show or other than "natural", or Itema 23a or 28a-f show ovent, the Madical Examiner must be untillised at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 TYYes 2 ☐ No If Yes, Give Year or Dates:			Was Decedent of Yes, specify Co			ofy Yes or No lican, etc.)		Race - Americ Black, White, pecify: Wh	
2-003p	72 hou	eted	15. Decedent's Ec (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usual Occ kind of work dor DO NOT use reti	supation ne during mos	st of working	9	16b. Kind	of Business/In	dustry
121	within then then	Completed	Elementary/Secondary (0-12) 12 vears	College (1-4or 5+ 5+ year				red)				ed Stat rnment	es
ט פ	Hygiv other	Be Co	17. Father's Name (First, Middle, Last)		5	- բաթ	Loyee	18. Moth	er's Name	(First, Middle			
yland		ToB	Robert E. Lee Win	ngate						Heidn			
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship				ng Address (Stre						
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Bonita Wingate  20a. Method of Disposition	(wife)	20b. Pla	Ce of Dispo	Aviation (Name of natory or other p	on Blvd		en Burr		ary Land tion - City or To	
E	nit. Pages partment of l cortant: If its injury or o		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )				Cremator		-1-20	006	Balti	more, M	laryland
Baltimore,	permit. Departr Imports eny inje		21. Signature of Funeral Service Licer	Wayne Oste	rling	g 23	Name and Add Cully-P 37 E. Pa	olynia olynia tapsco	k Fun	neral H Balti	lome, more,	P.A. Maryla	and 21225
		1	23a Part1. Ententhe disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. e.	Do not ent							Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate-Cause (Final disease or condition resulting in death)	a. Cardio	CONSEGUE	men	arya	rres1	se	Cond	ary	to	
	Examiner		Sequentially list conditions	ь Муоса	A .		farct				)		
i de la companya de l	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due o (or as a	conseque	ence of):	22+	Pa:1					
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3/60,	# % @	cal	(	d									
× 68	leath certificat attending phy I for use as th	/Med	IF FEMALE:	23c. If yes, outcome o	of pregnan	cv					224	d. Data of dalar	004
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal o	death 3	Ectopic pregnal Other (specify)				230	d. Date of delive Month	Day Year
2	res that tigned by	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the u	nderlying cause	given in Part	l.		1		he cause of death?
ord	w require been sign should b									-	Yes 2□I		oably 4 □Unknown
Division of Vital Records,	nysician: The law his certificate has b i director, page 2 st	Completed								24a. Was auto perfe 1 \( \text{Yes} \)	psy primed? 20 No	24b. Were auto prior to co death? 1 \(\sum Yes\)	ppsy findings available impletion of cause of
<u> </u>	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	· 2□ E	R/Outpatier	nt 3 DOA	Othor		(Check only		Other (Specia	6.1
o	ding Phy. h. Alter this funeral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time o		njury at Vork?		8d. Describe			у)
Sior	eath. or: Alt	catlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	1	7 6417			Yes 2					
Ž	l or Att after d Direct d in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At hon . <i>(Specify)</i>	ne, farm, sti	reet, factory, offic	00	2		(Street and I wn, State)	Vumber or Rur	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: Alter this certifics completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best o niner: On the basis of and manner stat	examination	rledge, deat on and/or in	h occurred at the vestigation, in m	time, date a y opinion, dea	nd place, a ath occurre	nd due to the	cause(s) ar date and pl	nd manner as s ace, and due t	stated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	^				ense number	1			signed (Month,	
	LV.Y		Alkhalil	MD			RE	50	01		Mara	ch 2	8 2006
	5+1		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print)	018.1	toun.	ier st	. Po	timaro	, MD, 21225
36	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	иге 🍰	Areste)	-, J:I	10-10-10-1	<u> </u>		THE T	1111116162
130	Regist	rar	MAR 3 1	2006	gard.	So 1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 26, 2006 Year **Physician** Wiitala 9:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3504 Woodring Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth July 29, 1923 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Pennsylvania 200-20-2348 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 □ No N/A Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itema 23a or 3504 Woodring Avenue 21234 USA e filed within 72 hours after death vil Hygiene. Other then "natural", or Itema 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify.White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any njury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Goffrey Mary Lecorcheck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eino Wiitala/Husband 3504 Woodring Avenue Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/30/06 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton Te Name and Jode Rus of Facility 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician lyocardial /Medical Due to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physicien ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Day 4☐Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ icete hes been sig , page 2 should b 1 ☐ Yes 2 Tho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Standarde 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) δ 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052543 March 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Naman, no Raven Baltimore bluck Loch Mb 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 Registrar

ORIGINAL

			1 - For State Registrar	State of Maryla	nd / Depa		Health and	Mental Hyg	211116	19993
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Las	AM	WE	BE	R	2. Date of Dea Month May Ch	29 2°01	
	Examir Funeral	ner	Social Security Number	EOURS H	OSP, TX s. last birthday)	If Under 1 Year	If Under 24 Hrs	MORE  S. B. Date of Birth		
	Director		212-60-4717	0.0	Yrs.  City, Town or Loc			June 13	, 1952 M	arýland  10d. Inside City Limits
	the Maryl 28s-f sho	ector	Maryland Baltimore		-	Ltimore	City		0g. Citizen of What C	X(X) Yes 2 □ No
	s 23a or	erai Dir	421 S. Vincent St			2	1223		USA	
9800	within 72 hours atter death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Madical Examinar must ke notilied at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 🏄 🛣 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes ※X ☐ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Inportant: If item 27 is marked other then "natural", or Items 23a or 28s-f show enportant: If item 27 is marked other then "natural", or Items 23a or 28s-f show any figury or other treumatic event, Ite Medical Examinate must be notified at ances.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 9th grade	(ucation de completed)  College (1-4or 5+)  N/A	16a. Deced (Give I life. D		pation a during most of wo ad)	1	16b. Kind of Business  Moving & S	
Maryland ;	wild be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Henry R. Weber, Ju		•			me (First, Middle, i ry Frank	Maiden Sumame)	
, Man	and 2 sho satth and n 27 is mu		19a. Informant's Name/Relationship (7 Marsha Weber (Sist	ter-in-law)	2504	Edwards			; City or Town, State, . Hill, Md.	
Baltimore,	Pages 1 tment of He tant: If iter jury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State  Sac	Place of Dispos cemetery, crem cred Heart	atory or other pla	Cem. 4-3		20c.Location-City or Baltimore,	
Bal	Departition Departition Departition Departies on Section 2002		21. Signature of Funeral Service Licen	soo	22. 	Name and Addr assahn 7401 Bel	Funeral l air Rd. l	Home Baltimore	, Md. 2123	6
	Physician /Medical		23a. Part1. Enter the disease, or companies, or companies, or companies, or companies, or companies, or companies, or companies, or companies, or condition resulting in death)	one cause on each line.	TAGE.		ing, such as cardia		est,	Approximate Interval Between Onset and Death
	Examiner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. UPPEI		ASTRI	DIATE	STINA	L BLE	EDING
3760,	ate be executed hysicien and the burial-transit	icai Examiner	Cause, Disease or injury that initiated events resulting in death) Last	c. FND SH Due to (or as a conse	AGE equence of):	KEN	AL D	ISEAS	SE	
Box 687	ertificate ding phys se as the		IF FEMALE:	23c. If yes, outcome of pregi	2000					
P.O. Bo	w requires that the death certifica been signed by the ettending ph should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗍	Ectopic pregnand Other (specify) _	у		23d. Date of del	ivery Day Year
rds, F	tuires tha n signed uld be det	Ď	Part II. Other significant conditions co	ontributing to death but not re	esulting in the un-	derlying cause gr	ven in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
al Records,	Attending Physicien: The law requires that the death certificate be executed to death. The family redeath.  redeath.  ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
<u> </u>	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		10**	hor	ath Check only on		
5	Phys this ral di	٦.	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of	30 004	4 🗆 INUESTING F		ence 6 Other (Spe	cify)
Division of Vital	or Attending Phy ter death. Irector: After this by the funeral d	ation	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 28c. Inju Wo	rk? ]Yes 2∐No	280. Describe no	ow injury occurred	
DIX	P P P P	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	cify)	•		City or Towr		
	To the Hospital or within 24 hours effu to the Funeral Dir completely filled in	edical	one)	ysician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the ti estigation, in my	ime, date and place opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of certifier	R. Crn	Zm.	29c. Licen:		55 1	9d. Date signed (Monte	n, Day, Year)
3	1		30. Name and address of person who c	ompleted cause of death (lite	3a) (Type, P	7 - D	BON	SECOL	March 2 LRS fo	SPITAL
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 3 1 2006	32. Registrar's Sign	nature	9				1

Jeanne Dietz Wilson 06-02117 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,2528a from WE 1854/16/15/06 The of Health and Mental Hygiene crn Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 26 Jeanne Marie Wilson 2006 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kingsville If Under 1 Year | If Under 24 Hrs. Baltimore 12409 Belair Road 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Yrs. 04/09/1942 63 Maryland Director 218-40-7542 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Kingsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12409 Belair Road 21087 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaking Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ٥ Amelia Marie Thomas John Garrett Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: if item 27 ie eny injury or other treu <u>once</u>. William W. Wilson (husband) 12409 Belair Road - Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 03/31/2006 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Contact gunshot wound of head /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ves 2 No 24a. Was an autopsy performed? 12 Yes 2 No 25. Was case referred to medical examiner?
1 △Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) at scene 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending Fnd 2:32 P 1 ☐ Yes 2 🗓 No 2 🔲 Accident investigation 3/28/2006 subject shot self 3 X Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12409 Belair Rd. Kingsville, MD 4 | Homicide House 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUB10 MD 111 Penn Street, Baltimore, Maryland 21201 egistrar's Signature 31. Date filed (Month, Day, Year) 32. State MAR 3 1 2006 Registrar

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				1 - State of Maryland / Department of Health and Mental Health And Mental Health And Mental Health And Mental Health And Mental Health And Mental Health And	Hygie	ne Philippo	naggs
					Reg.	No.	
		hysici: /Medic		Triscilla D. Washington  2. Date of Month Mayor	,	Day Year	3. Time of Death
		xamin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  SINA' HOSPITAL 2401 W Belvedeve Baltimore		4c. County of Deat	7 <sub>0</sub>
	Fu	neral		5. Social Security Number 6. Sex 7. Age (In,yrs., Jast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of	Birth	9. Birti	nplace (State or Foreign
		ector		ZZ6-52-8488 1□M 2	16-19	940 VII	RCINIA
	larylano	anow act at	7	10a. State 10b. County 10c. City. Town or Location			10d. Inside City Limits
	<b>5-0036</b> 72 hours after death with the Maryland	trent of its marked crime trien institute, of thems as of 2884 ency other traumatic event, the Madical Examiner must be notified at	by Funeral Director	10e. Street and Number  10f. Zip Code	10g.	Citizen of What Co	1 Nes 2 No untry?
S	ath wit	ust be	raiD	1525 MEDFORD RD 21218		4.5.	A
-	eb ret	miner must	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 2 Narred  12. Was Decedent Ever in U.S. Armed Forces?  1 No	No-	14. Race - Ame Black, White	ican Indian, o, etc.
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ب		edical Ex	ietec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working		. Kind of Business/I	1
2	nd 2121 e filed within al Hygiene.	the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  MICRO BIOLOGIST	121	LABOR	
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	Marylan 2 should be and Mental	natic	은		Clyo		
1	<u>==</u> p = ;	rtraun		19a. Informant's Name/Relationship (Type, Print)  Vanessa Washing ThN - Redd 3517 Brendan Ave Ba			21213
Priscilla	Baltimore, M Permit. Pages 1 and 2 Department of Health	r oth		20a. Method of Disposition 20b. Place of Disposition (Name of Date	_	Location - City or 1	
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C	Baltim permit. Pag Department	eny injury or o		21. Signature of Fuperal Service Licensee	1 6	uneril	Home
				23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, shert as cardiac or respirator	v arrest	ms 2	Approximate
	Phys	ician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  COVMANY Artery DISEAS			Interval Between Onset and Death
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and	tached for	Physician/Med	in the past 12 months?  1	_	23d. Date of deliv Month	ery Day Year
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	ords equire	should b	Ted I	Diabetes Mellitus, Seizure Disorder	Yes	2 X00 3 □ Pro	oably 4 Unknown
	Aec e faw r	page 2 sh	Completed		topsy	24b. Were auto	opsy findings available impletion of cause of
	Vital   Vital	tor. pag		TE Was and address of the Control of	_	death?	2 No
	f Vir	direct	0	26. Place of Death Check only seamine?  1   Yes   2   Mo		6 COther (Cree	6.3
	ng Ph			27 Manney of Dooth		ury occurred	<u>y</u> /
	ISIO ttendi death.	the ft	Cat	2 Accident investigation M 1 Yes 2 No			
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director:	ed in by	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	i (Street a Town, Sta	and Number or Rura ite)	al Route Number,
	Hospi 24 hour	ately fill	edicai	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	ie cause( e, date ar	(s) and manner as s	tated.
	To the within	сошрі		29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month,	Day, Year)
	or			J Lechael Anderson UD D28126			
	8			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thuch a el Ancienta M. 2401 w Bolveder Are  31. Data filed (Month Day Year)  32. Registrate Signature		0-14	111
		State	2	31. Date filed (Month, Day, Year)  39. Registrar's Signature	1 10	Janne	ITE MU
	Re	aistra	,	MAD 3 1 2006 Rep M. Agreed B			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Geraldine 25, Williams March 2006 2:10 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2122 W. Patapsco Avenue Birthplace (State or Foreign Country)
 Mary land If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 52 7-6-5 216-58-0971 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminations the notified at 1 Yes 2 □ No **Funeral Director** NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 2122 W. Patapsco Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory 10 Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Jessie Mae Williams James Anderson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tof Health : if item 27 is James McDonald/ Husband 2122 W. Patapsco Avenue Baltimore, MD 21230 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 03-31-2006 Loudon Park Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part 1. Enter the disease, gramplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervaf Between Onset and Death Immediate Cause (Final ypan OVacian **Physician** Cance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: use a . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Oav jo 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 28. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOYNE 1 ☐ Yes 2 ☐ Yo 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospice After 1 Natural 2 Accident Injury 5 Pending 1 Tes 2 No death. investigation To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatore and title of certifier March 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BALTIMORE MD 21202 IM MD ST PAUL DWIGHT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AEM 06-02068 Henry White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#1, 23a, 27, 28a-f, / PerME 1, 2854, 4/12/06 The Montel Hygion 2 0 0 0

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į	1 1		1. Decedent's Name (First, Middle, La	est)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		Henry T. White Jr.					March 2	24, 2006 Yeer	1:19 PM
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death	,	4c. County of Dea	ath
			University Hospi	tal			ore City		N/A	
	Funeral Director		210-30-1029	Sex 7. Age	66 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12–16–1		rthplace (State or Foreign ountry) ryland
	ow a		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e-fah	Director	MD	NA	Baltimo	re				1 X Yes 2 □ No
	th th	ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
	23a	al	819 W. Lexington St	reet Apt 12		212	.01		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heatth and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or Itams 23a or 28e-1 ahow any Injury or other traumatic avant, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🖔 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔏 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Bla	ite, etc.
Ò	2 ho	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation		16b. Kind of Business	
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Maryland 21215-0036	d be fil	To Be	17. Father's Name (First, Middle, Las Henry T. White Sr.	1)			18. Mother's Nam Alfreda		Maiden Sumame)	
2	shoul nd Me mark	ř	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Number	r, City or Town, State,	Zip Code)
	nd 2 alth a 27 is		Romaine Thomas/ Frie	nd	819	W. Lexingto	n Street Ap	t 12 Balti	imore, MD 212	:01
Baltimore,	Pages 1 a nent of Her int: If Itam iry or othe		20a. Method of Disposition  1  Burial 2XXCremation 3 { 4  Donation 5  Other (Special Control of the Control of		20b. Place of Disp cemetery, cre Metro Cren	osition (Name of oration) or other planatory	(03-30-		20c. Location - City o Catonsville,	
ä	permit. Deperting Imports any Injure.		21. Signature of Funeral Service Lice	nsee	2	22. Name and Addre				
	₹05 # a		23a. Part1. Enter the disease, or con	Jones					or Street Bal	Approximate
68760,	Physician and /Medical Examiner transit as the burial-transit	edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	intoxication a consequence of): a consequence of): a consequence of):	n and cocain	ne use			Interval Between Onset and Death
P.O. Box 6	the death cert by the attendin ached for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of de Month	elivery Day Year
	w requires that been signed to should be det		Part II. Other significant conditions	contributing to death bu	at not resulting in the	underlying cause giv	en in Part I.	23e. Did tot	pacco use contribute t es 2 No 3 □ P	o the cause of death?
Division of Vital Records,		Completed						24a. Was a autops perform	ned? prior to death?	utopsy findings available completion of cause of s
₹	Physician: this certific ral director,	Be C	25. Was case referred to medical examiner?	Hospital:		at all non Oth	26. Place of Death			
ŏ	Phys ral di	2	1 XYes 2 No 27. Manner of Death	28a. Date of Injur	v 28b. Time o	III 3 LI DOA	4   Nursing no		ence 6 Other (Spe	ecify)
ion	Attending ir death. ector: After by the funer	ation	1 □Natural 5 □ Pending 2 □ Accident investigation	n Fnd 3/24/20	Year) Injury	Wor	k? Yes 2X No U	nk	on injury occurred	
Divis	F 8 F C	Certification:	3 ☐ Suicide 6 🛣 Could not t 4 ☐ Homicide determined	building, etc	ry - At home, farm, si . (Specify) residence	reet, factory, office		28f. Location (St City or Town Apt. 12. ]	reet and Number of Fi n. State) 819 W. Baltimore. MI	Saratoga St.
	To the Hospitel of within 24 hours af To the Funeral D completely filled it	edicai C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	f my knowledge, dea examination and/or in	th occurred at the timestigation, in my o	ne. date and place.	and due to the ca	ause(s) and manner a	s stated.
	To th withir To th	Me	29b. Signature and title of certifier	11		29c. Licens		2	9d. Date signed (Mon March 25,	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)		Raltimo:	re, Maryla	
	Sta	10	31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	1	mi pricer	DOT CTINO!	raryra	IN ZIZOI
	Registr			006	· JE A	ask)				
P1 .	MALL AND DOOR	104								

			1 - For Stata Registrar	State of Mary				lealth a			giene	006	09998
			Hegistrar     Decedent's Name (First, Middle, Last,			7111104		Douin		2 Date of De			3. Time of Death
* 5	Physici	an								Month	Day	Year	
	/Medio		Altee E. Atk							March		2006 county of Death	2:00P M
1	Examir	er	4a. Facility Name (If not institution, give			1		r Location of	of Death		46. 0	ounty of Death	1
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Southern Maryl				lint		24 Hrc	0.0		ince (	Georges
1	Funeral		5. Social Security Number 6. Security Number	x 7.Age (In ]M 2 SyF	yrs. last birthday,	Months	Days	Hours	Min.	8. Date of Bird (Month, Da	n y, Year)	9. Birth	hplace (State or Foreign untry)
420	Director		5/8-36-3310		74 Yrs.					April	17,1	931	VA
-	pu 🖈		Usual Residence of Decedent  10a, State 10b, County	10	c. City, Town or L	ocation							10d. Inside City Limits
	aryla Shon	<u>.</u>	Toa. State	10	o. Ony, 10441 of L	.004(1011							1 ⊠Yes 2 🗆 No
	Ba-f	cto	Md. PG		Capit			nts					
	or 2	Jire	10e. Street and Number			10f. Z	ip Code				10g. Citize	en of What Co	untry?
	23a	by Funeral Director	1207 Addison Ro	ad South	#103		207	743			Un	ited	States
	dea En	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dec	edent of H	lispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 14	<ol> <li>Race - Amer Black, White</li> </ol>	
9	after or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 🗆 Yes		Specify:				annihe:	
ဗ္ဗ	ours	ō	3 ∰Widowed 4 □ Divorced	Year or Dates:			2,2,110	- Open, y .				Bla	ack
21215-0036	72 hours after death with the Maryland natural', or itama 23a or 28a-f show dical Exant, ar must be incitiled at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	edent's Us	ual Occup	ation during mos	t of work	na	16b. Kind	d of Business/	Industry
2	within ene.	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	d)					
2	Gien Kil	- C		4	Psych	niat	ric	Asso	cia	te	DC	Genera	al Hosp.
D	illed il Hygi other	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	e (First, Middle,	Maiden S	lumame)	
a	td be ked ked ic	To B	Paul Thurston					LOU	ise	Walk	er		
Maryland	Shound N	-	19a. Informant's Name/Relationship (7)	rpe, Print)				and Numbe	er or Rura	al Route Numbe		Town, State, Z	Zip Code)
ž	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examples coulded a		Laura Byrd Pett	away/daug	hter á	2305	Aft	on S	tree	et		0710	
စ်	Hea Hea Sthe		20a. Method of Disposition	2	Ob. Place of Disp cemetery, cre	osition (Na	ame of	1115	7 112	ary Lan	20c. Loc	ation - City or	Town, State
Baltimore,	00 ± ± 5		1 ⊠Burial 2 □ Cremation 3 □F	temoval itom State				1					
Ë	mit. Par bertmen sortant: injury		4 Donation 5 Other (Specify)		ld. Vet	eran	s Ce	em. 4					
Sal	Depermine Deperm		21 Signature of Funeral Service Licens	99				ss of Facili	4.1	odges			
	207 a 0		Hime cel	evuo								land,	MD.20746
			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the ne cause on each line.					cardiac (	or respiratory a	rrest,		Approximate Interval Between Onset and Death
T.	Physician		Immediate Cause (Final disease or condition	End Stage	Ovana-	~ Car	ren						unknown
6	/Medical		resulting in death)	Due to (or as a co	nsequence of):								
	Examiner			b									
	350	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):								
V	sicien end burial-transit	Examiner	Cause (Disease or injury that initiated events										
Ġ	exection on the section of the secti	Exe	resulting in death) Last	Due to (or as a co	nsequence of):								
760	ite be iysicie ne bui	cai		d									
68	ficate p phys												
Вох	death certifica e attending ph id for use as tl	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p							23	3d. Date of deli	ivery
ĕ	eath atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic □ Other (:		<i>y</i>				Month	Day Year
P.O.		Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown									
	law requires that the deas been signed by the a	급	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying	cause giv	en in Part I	l.	23e. Did t	obacco us	e contribute to	the cause of death?
Division of Vital Records,	sign d be	d by	Upper Gast	wintertine	1 buch	_				10	Yes 2□	No 3∏Pr	obably 4 Honknown
0	v requir been s should	Completed								04-146		041 144	According to the second section of the section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the
ec	e law has t	npi								24a. Was	osy	prior to death?	utopsy findings available completion of cause of
Н	Th ate	Con								1 Yes	rmed?	1 Tyes	2 10
ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						e of Deat	h (Check only o	ne)		
<b>1</b>	8 × F	2	1 Yes 2 No	Hospital: 1 Impatient	2 ER/Outpatie	ent 3 🗆 🛭	OUT OUT	ner: 4 □ Nu	ursing Ho	me 5 Resi	dence 6	Other (Spec	cify)
0	ding Phy th. : After thi		27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Time (	of	28c. Injui Wor	ry at		28d. Describe	how injury	occurred	
<u>0</u>	ath. T: Aft e fur	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 22)	,,	М		Yes 2□	No				
<u>S</u>	or Attending after death. Director: After in by the fune	110	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	At home, farm, s	treet, facto	ory, office			28f. Location ( City or To		Number or Ru	urai Route Number,
á	after Dire	Certification:	4   Hornicide	building, etc. (S	респу)					City of 10	wii, State)		
	Hospitei 24 hours a Funerai C		29a. Certifier 1 Certifying Phy	sician: To the best of m	y knowledge, dea	ith occurre	d at the ti	me, date ar	nd place,	and due to the	cause(s) a	and manner as	s stated.
	24 h 24 h Fui etely	dicai	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated	amination and/or i	nvestigatio	on, in my o	opinion, dea	ath occur	red at the time,	date and	place, and due	to the cause(s)
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			2	9c. Licens	se number			29d. Date	signed (Mont	h, Day, Year)
	F 3 F ö		> puit pr	M.	0.		1	2470	261			7.27.00	<i>(</i> .
	1.				(II 20-1 =			. ,	. 76	-		・イエの	5
	7		30. Name and address of person who co		(Item 23a) (Type	Ses	is A	ne. (	+7.	41 01	sa S	pring ,	~2090Z
				1 - 455	Signality A	and a	9 276	الدر ال	/ )-	10 3.1		)	-11 0 1 0
	Sta Registi		31. Date filed (Month, Day Year) 20	06 38 Begistrar's	To pay	Harris &							

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene 0 0 6	09999
	Physic /Medi		1. Decedent's Name (First, Middle, L ELSIC LOU		nderson	2		2. Date of Dea Month	th Day Year 20 06	
	Exami		4a. Facility Name (If not institution, g. PRINCE GEOR	ive street and number) GE HOSPI		CHEVE	, ,	MD	4c. County of Dea	ath
* D	uneral irector		5. Social Security Number 6. 577-56-8780  Usual Residence of Decedent	Sex 7. Ago 1 ☐ M 2 🔀 F	e (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 2	Year) C	rthplace (State or Foreign Country) Wash., DC
h the Maryland	or 28a-f show	Director	10a. State 10b. County  MD P  10e. Street and Number	G	10c. City, Town or Lo			1	0g. Citizen of What C	10d. Inside City Limits 1X Yes 2 □ No country?
5-0036	in y your in the matural, or items 23s or 28s-1 show of other than matural Examinating at event, in a Madical Examinating at	Funeral	119 Harry S.  11. Marital Status  1 Never Married 2 Married	Truman Di  12. Was Decedent   Amed Forces?  1  Yes, Give	Ever in U.S. 13.	207 Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Spe n, Mexican, Pueno F	cify Yes or No- Rican, etc.)	United S  14. Race - Am Black, Wh Specify:	erican Indian,
21215-0036 od within 72 hours af oriene.	nen "natural", Medical Ex	Completed by	3 Widowed 4 Privorced  15. Decedent's 8 (Specify only highest g.  Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give	dent's Usual Occupa	ation during most of working	ng	B]	Lack
land 21	ked other th	To Be Cor	12 17. Father's Name (First, Middle, Las Oscar Parham	t)	Se	ecretary	18. Mother's Name	(First, Middle, M	Govern Maiden Surname)	nment
Mand 2	If item 27 is marked or other traumatic ev	-	19a. Informant's Name/Relationship Gary Anderson		Fort	Washin	Road #3	Route Number	City or Town, State,	Zip Code)
Baltimore permit. Pages 1 a Department of He	Important: If item sony injury or other		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Spec  21. □ nature of Funeral Service Lice	ify)	Place of Dispo cemetery, crem Ft. Linc	sition (Name of natory or other place coln Cem	a) 3/28/	<sup>4</sup> 06	Brentwoo	od, Md.
Ba Ba	eny ir		23a Parl . Enter the disease, or congrided on the congrided of the congrid	Club Cu	the death. Do not ent		er Hill	Rď., S		Md. 20746 Approximate
/M Exa	sician edical miner	lner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causa. Energy Jordyng Cause (Disease or injury)	a CARI  Due to (or as a		RRHY	THMIA			Interval Between Onset and Death
8760, <- cate be executed	physician and s the burial-transit	dical Examiner	Cause (Disease of Injury that infliated events resulting in death) Last	cDue to (or as a	a consequence of):					
Division of Vital Records, P.O. Box 6 To the Hospites that the death certific within 24 hours after death.	led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, P.	been signed t should be deta	þ	Part II. Other significant conditions ATRIAL FIBY	contributing to death bu		idertying cause give	n in Part I.		acco use contribute to s 2 ⊠No 3 □ P	o the cause of death?
tal Rec	ate has page 2	Completed	HTN, HYPO  25. Was case referred to medical	THY ROIDIS	M, MITR	AL VALV	MENT	perform 1 Yes 2	prior to death?  No 1 Yes	utopsy findings available completion of cause of
of Vij	w ==	To Be	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 Inpatien		3□ DOA Othe	26. Place of Death r: 4 ☐ Nursing Hom		a) nce 6 □Other (Spe	cify)
Division of Vital Records, tor Attending Physician: The law requires that death.	After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	e Ricco of Injur	ry - At home, farm, stre	28c. Injury Work M 1 \( \text{Y}	at 28 ? ′es 2 □ No	3d. Describe ho	w injury occurred eet and Number or Ri	
Hospitei o	To the Funerel Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one)  12 Certifying Pl	nysicien: To the best of miner: On the basis of and manner state	f my knowledge, death	occurred at the time estigation, in my op	e, date and place, ar Inion, death occurred	City or Town, and due to the call d at the time, da	uso(s) and manner as	s stated. e to the cause(s)
To the within	To the	Me	29b. Signature and little of certifier  La pur	i, MD	)	29c. License D006			d. Date signed (Mont	
1	15	1.	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, F PRINCE	Print) GEORGE	= HOSP	ITAL	CHEVE	RLY, M.D
	Sta Registra		31. Date filed (Month, Day, Year)	37 Registrar	's Signature	de .				

			For State Registrar	State of Ma	arylan	•	artmen rtificat			d Mer		iene	06	10000
			Decedent's Name (First, Middle, I	Last)			Rib				Date of Deat		V	3. Time of Death
	Physici		Mary Elizab	eth And	es						Month March	Day 18	Year 2006	8:20 A <sup>M</sup>
1	/Medio Examir		4a. Facility Name (If not institution, g				4b. City,	Town, or L	ocation of De		101 011		inty of Death	
			26575 North San	dgates Road			Mec	hanio	esville	2		St	Mary'	C
	Funeral			. Sex 7. Ag		last birthday)			if Under 24 H	irs. 8.	Date of Birth (Month, Day,		9. Birth	place (State or Foreign
	Director		216-32-0213	1 □ M 2 □ F	7	O Yrs.	Months	Days	Hours M		av 27.	1935	1	yland
	<b>D</b> _		Usual Residence of Decedent											<u> </u>
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	W	cto	MD St. Man	ry's	Mec	hanics								1 Yes 2 No
	हैं 2 दे 3 दि	O ire	10e. Street and Number				10f. Zip	Code			10	g. Citizen	of What Cou	intry?
	23a	Funeral Director	26575 North Sand	<del></del>				20659					5. A.	
	ep u	- Pu	11. Marital Status	12. Was Decedent   Armed Forces?		.S. 13.	Was Deced If Yes, spec	dent of His cify Cuban	panic Origin? , Mexican, Pu	(Specify ierto Rica	Yes or No- an, etc.)		Race - Amer Black, White	
36	s afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		1 ☐ Yes	2⊠ No	Specify:			Spe	city:	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f ehow ha Madigal Examinar must be notified at	D D		Year or Dates:		16a Dasa	doot's Have	-1 0	i==			ICh Kind o	Wh f Business/fr	ite
쟌	"naf	Completed	15. Decedent's (Specify only highest)			16a. Dece	kind of wor DO NOT us	rk done du	ring most of v	working		IOD. KING O	i Dusiness/ii	idustry
7	withi ane. then	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homer						A . TT		
2 D	Hygi Hygi ther int,		17. Father's Name (First, Middle, La	st)		Homei	nakei	1	18. Mother's N	Name (Fi	rst, Middle, N	At Ho laiden Sun		
ă	od be od o	Be.	Charles Childs						Marga	rot	Elizab	oth 1	****	
2	hould Me mark	င္	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address	(Street an	nd Number or					p Code)
Maryland	d2s thar t7 le		James A. Andes S		a d			,				•		
	Heal Heal		20a. Method of Disposition	/I. / Ilusbai	20b. P	Place of Dispo	sition (Nan	ne of	-1	Date			on - City or T	MD 20659 own, State
<u>ē</u>	nt of nt of t: If it		1 ☐ Burial 2 ☑ Cremation 3			emetery, crei				rch	-	1 7		-11 MD
Baltimore,	ortme ortan injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Br	insfiel				2006 •				all, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		four 18	486		0641   30	195 7	Three	Notch	Rd.	Char1	otte	s Fun. <u>Hall,</u>	L.Hme.,P.A. MD 20622
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused ity one cause on each lir	the deat	h. Do not ent	er the mod	e of dying,	such as card	liac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	Pnysician	0.2	Immediate Cause (Final disease or condition	. G	101	olas	ton	na						onsot and boatt
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):								
	Examiner	. 1	Sequentially list conditions.	b										
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								
	ecute and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for se										
8760,	ate be executed thysicien and the burial-transit	E E		Due to (or as	a conseq	uence or):								
876	physic physic the b	dicai		d						•				
P.O. Box 6	leath certific ettending pl	Physician/Med	IF FEMALE:	22a Wusa sutasma	of 0.0000								-1457 - 61-0	
80	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3	Ectopic pr						Date of deliv Month	ery Day Year
<u>.</u>	the e	/sic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of d	eath 5	Other (sp	ecity)						
	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the u	nderlying c	ause given	in Part I.		23e. Did tob	acco use c	ontribute to	he cause of death?
Records,	w requires t been signe should be	d by									1 ☐ Ye	s 2 18 No	3 🗆 Pro	bably 4 Unknown
ö	v req	Completed								_	24a. Was an	24	h Were aut	opsy findings available
ě	has pe 2	m D					_			-	autopsy	,	prior to co	impletion of cause of
<u>_</u>	n: Th ficete r, pa		05 Man ann afamad in madical									Ø No	1 🗆 Yes	2 No
⋚	sicial	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		50/0:		Other	26. Place of D					
ō	Physr raidi	٠ <u>.</u>	1 Yes 25 No	1 ☐ Inpatie		ER/Outpatier 28b. Time of		<u> </u>	4   140131110		5 Reside			(Y)
5	ding h. Afte fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	м	8c. Injury a Work? 1 □ Ye	s 2∐No			, ,		
Division of Vital	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be 200 Place of Init	urv - At ho	ome, farm, str				28f.	Location (Str	eet and Nu	mber or Rur	al Route Number,
2	rs after al Dire ed in b	Certification:	4 Homicide determine	building, etc	c. (Specif	y)		,			City or Town	State)		
	To the Hospital or Attending Physicien: The law within Z4 burus after death.  To the Funeral Director: after this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying 1 (Check only one) 2 Medical Ex	Physicien: To the best of aminer: On the basis of and manner sta	examina	wledge, deat! ition and/or in	h occurred vestigation,	at the time , in my opir	, date and pla nion, death oc	ace, and ccurred a	due to the ca t the time, da	use(s) and te and plac	manner as see, and due t	stated. o the cause(s)
_	Vithin To th COMP	ž	29b. Signature and title of certifier		,	\		. License		-1	29	d. Date sig	ned (Month,	Day, Year)
			> 0V2	11	~	,		400	557	7 1		Marcl	n 20,	2006
			30. Name and address of person wh	o completed cause of d	eath (Iten	n 23a) (Type,								
_			JENNHER	Schim	Tb	808	NOC	130	> HC	NU	wdt	nd	206	36
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0	2006 32 legistra	ar's Signa	ture	and s			J				

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ORIGINAL